

The Tavistock Clinic and the University of East London

**“The shadow falls”: Understanding the factors
involved in decision-making in local authority
children’s services**

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Declaration

This work has not previously been submitted for any degree and is not being concurrently submitted in candidature for any degree. This thesis is the result of my own research and other sources are explicitly acknowledged.

Signature.....

Date.....

Abstract

This research explores outcomes for 31 children in 17 families, from parenting assessment work undertaken by the author in her role as an independent social worker, for a local authority between 2006 and 2008. The data collected in the course of the work was used in order to identify themes and patterns across cases, to form an understanding of the common difficulties faced by families in complex child protection cases. The assessments were followed up with interviews with the social workers to find out what had happened to the child or family. The themes arising from these two sets of data are presented as case studies, highlighting common themes about the psychodynamic factors affecting decision making in child protection work and the emotional impact of the work. The study describes a process whereby the social worker can lose sight of the child's needs due to the overwhelming needs of the parents. The findings advocate a process of containment through a model of reflective supervision, which takes account of the emotional impact of the work, bringing the child back into focus whilst not losing sight of the parent's needs. A process of reconnection with the tragedy behind the cases is also described. This study demonstrates how difficult it is for one lone social worker to keep the parent and child's needs in mind and therefore advocates for a team approach to complex child protection work.

Key words: Child protection, complex cases, stuck cases, drift, delay, emotional deprivation, impact, unconscious processes, decision making, psychodynamics, psychoanalytic theory, child abuse, Klein

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Introduction

“It’s like letting a toddler loose on the M25”

This imaginative comment was made by my research supervisor, Andrew Whittaker in a discussion we were having about how to describe the emotional impact of child protection work, particularly on newly qualified social workers. This throw away comment struck me as capturing something important about the expectations we place on newly qualified workers and highlights their unpreparedness for the enormity of the task. Whilst this study was not specifically about the experiences of newly qualified social workers, and involved interviewing social workers from a range of different levels of experience, most of them were relatively new to child protection work and in particular, very new to care proceedings work. The interviews with ten social workers explored their experiences of the child protection work they had undertaken, with a specific interest in how the emotional impact of the work and unconscious processes affected their decision making. The interviews highlighted the central importance of relationships, past and present and the impact of emotional deprivation in the parent or child on social worker judgement.

The research also examined my own practice as an independent social worker, undertaking parenting assessment work in complex child protection cases for a local authority in the London area. It reviews the outcomes for 31 children I undertook parenting assessments for between 2006 and 2008. It describes the development of ‘research mindedness’ in the practitioner (me) through a process of practitioner evaluation (Shaw, 2011). Expert witnesses rarely have the opportunity of seeing the consequences of their court reports and the outcomes for the children, which means that effectiveness is rarely evaluated, so practice remains uninformed of outcomes and therefore unchanged by them. Here, I have used an evaluative process to inform my practice, to identify areas that needed improvement, and to understand the general factors that can lead to improved practice in complex child protection cases. During the research process, I developed a model of parenting assessment and reflective supervision, informed with the new understandings that emerged from the study. Thus, the knowledge provided by this research has generated useful methods of intervention that can be passed on to other practitioners in the field.

Researcher’s Background

In 2005 I became an independent social worker after working as a children and families social worker for 9 years. I was commissioned by a Local Authority to undertake a number of parenting assessments. Initially I was asked to undertake assessments for 6

cases but was soon commissioned to undertake much of their more complex parenting assessment work. This role lasted until August 2013. At our first meeting the senior manager who commissioned me, told me that she was concerned about 6 cases in particular, as she thought that the social workers had become stuck in some way and the care plans for the children were drifting. She wanted to know what the next steps should be in terms of the longer term plans for the children. Most of the children were in short-term foster care, or kinship care, awaiting assessment to determine whether they could return home. Only one case involved children living at home. All of these cases involved chronic concerns about child abuse, usually involving neglect due to addiction. The request for a parenting assessment usually signified that the social worker, manager or organisation had exhausted their ideas about intervention with the family and it indicated a move towards more draconian measures of involvement, such as removal of the child from their family into care or, if already in care, permanent placement outside of the family. Many of the cases went into care proceedings where Care Orders were sought for the children.

Alongside my work as an independent social worker in children and families, I developed a keen interest in psychoanalytic ideas and the application of psycho-social approaches to social work practice. I developed this interest by attending the combined MA/Professional Doctorate in Emotional Wellbeing at the Tavistock Clinic/UEL. I was introduced to a way of thinking that uses psychoanalytic concepts about the unconscious in the context of; work discussion groups, infant observation, institutional observation, theory and social policy modules. This led me to become interested in psychoanalysis on both a personal and professional level. I introduced these ideas into my consultancy in a practical way by arranging regular clinical supervision with an adult psychoanalytic psychotherapist/senior social work lecturer, Marion Bower. This is a supervisory relationship which is ongoing. This helped me to cope with the emotional impact of the work and also helped me to reflect on projective processes, which gave me an increasing ability to view cases more clinically. After all, it was all too easy to identify with certain aspects of the cases and the people involved. Clinical supervision provided an independent view of the recommendations I made. Taking a clinical perspective, also helped me to keep a distance from organisational dynamics and recognise unconscious pressures from professionals and/or parents. In supervision, we would often look at what was being unwittingly re-enacted (Britton, 2005). We would also discuss structural issues such as inequality, gender, class or ethnicity in order to think longer term about the parent and child's support needs.

I have also used the clinical supervision relationship in the research, to develop a greater capacity for reflexivity. I arranged clinical supervision sessions in addition to the formal research supervision to discuss the dynamics of the cases and analyse the interview

material. These sessions articulated the emotional pressures and unconscious aspects of the cases that were acting on social workers, pressures that lead to what should have been clear cut decisions, becoming what we termed ‘muddled.’

The research was also a vehicle for disseminating knowledge through reflective supervision, lectures and seminars to newly qualified social workers, child protection practitioners, students and social work managers. This ability to build reflective capacities in myself and others will ultimately lead to better outcomes for children and families. Developing critical ‘reflective capacities’ in social workers that take into account unconscious processes is possibly the most important element offered by reflective supervision. I argue for a quality of supervision that can provide the emotional containment needed for this most difficult work. Understanding the role of anxiety and the unconscious defences we employ to protect ourselves from distress and pain is at the heart of this study.

Decisions and the Child Protection Task

‘Violence, screaming and distressed adults, babies failing to thrive and maltreated toddlers arouse anxiety in most people and it is extremely difficult to contain and handle this type of anxiety usefully. The problem for all social workers is how to make what is a natural and appropriate anxiety work for them and their clients and not against them all. But the more anxiety provoking the situation, the more difficult it is for the workers to hold on to their basic professional skills and ethical standards of work.’ (Mattinson and Sinclair, 1979. p-10)

This quote reminds us of what social workers involved in child protection work face every day and the maelstrom of emotions that this work entails. Fear, guilt, anger, hatred, anxiety, helplessness and despair go alongside, and at times hand in hand with more benign feelings of empathy, affinity, hope, care, compassion, concern, fortitude and love. Without knowing about the nature of the child protection task and the strong anxieties it can provoke, we will not fully understand the kinds of environments workers occupy; Socially, emotionally, psychologically and politically. The nature of the task (assessing child abuse) is disturbing, conflictual, uncertain in outcome, paradoxical and complex. Concerning matters of human vulnerability and failure such as inadequacy, irrationality, sadism or self-destruction. There can be no other work where the stakes for parents are higher, particularly in the area of care proceedings and adoption, where children may be permanently removed. Making a long term decision about the future of a child arouses very strong feelings in social workers, parents, children and other professionals. In these environments decisions may be put off, avoided, precipitous, or subject to unconscious processes, often mirroring the case dynamics (Mattinson, 1975). It is highly unlikely that decisions about children and their

families will be straight forward, particularly in disputed cases. The best interests of the child are never a clear cut set of criteria. They are a complex set of ideas based on value judgements within a historical context and are hotly debated and charged with conflict within an adversarial legal system (Dingwall, 1989). Severing the bond of a child from their family of origin can feel destructive to workers, who go into social work in order to help families stay together. Perhaps this is why the institution of the law is the main arena where these decisions are made in England. The reality is that no decision about a child's future can be certain and our ability to assess what has gone wrong, and to predict change in the future is always partial and fallible. Decisions with such significant repercussions are extremely anxiety provoking, to paraphrase Karl Popper, 'decisions with the greatest stakes arouse the deepest anxieties' (1979). From a psychoanalytic perspective, not only do straightforward adult anxieties get provoked in the course of this work, but also intense primitive anxieties are provoked, i.e. powerfulness, omnipotence, guilt, envy, fear of destructiveness. Taylor, Beckett, and McKeigue (2008) liken these decisions about children and their long term care to the 'Judgements of Solomon.'

These decisions have repercussions on the internal world of the social worker, which in turn affects their judgement and capacity to remain emotionally involved in the work. This arena is fertile territory for phantasy and primitive anxieties. Omnipotence and reparation are just two of the unconscious processes that can be involved in child protection work (See the literature review for a definitions of these concepts). Workers may have unresolved issues regarding their own family history or an unconscious wish to repair ill parents in phantasy, arising out of growing up in damaging family environments. Therefore, there are huge emotional costs for those social workers who experience parents who refuse to get better, who get worse, or even die. It was not within the scope of this research to examine the family background of the social workers and what their unconscious motives for going into child protection were, but would be useful to design research in the future that could lead to understanding about these 'background' emotional factors.¹

Chapter 1 examines the literature and theory that is relevant to this area of social work practice, highlighting the gaps which make this research unique and important to further our understanding in this area of concern. Chapter 2 describes and explains the methodologies used in undertaking the study and the epistemological positioning of this qualitative study. Chapter 3 sets out the main themes and patterns across the cases, taken from an analysis of the work undertaken during the parenting assessments. I present the themes and difficulties that are common to these specific families who are

¹ This would link to research into resilience in child protection social workers (a University of the West of England research project (2015) I am currently involved in).

involved with social services departments due to child protection concerns. In Chapter 4 I present the themes arising from an analysis of the cases and of the interviews with the social workers as vivid case studies which highlight the emotional and psychodynamic factors that affect decision making. In Chapter 5 I review the findings from Chapter's 3 and 4. The final chapter, Chapter 6 presents the main conclusions and the implications these have for practice. I argue that the models of social work practice concerning parenting assessment and reflective supervision can enhance decision making in complex child protection work, leading to quicker and safer decisions for children, parents and families.

1. Literature Review

Overview

This literature review is a critical evaluation of research and theory relevant to the research question about the emotional and unconscious factors in decision making and the extent to which this has been addressed by current and past social work research and literature. I highlight what may be missing from the literature about the emotional processes and unconscious factors involved in decision making. I cover a number of areas relating to the common themes contained in the case studies such as drift and delay, emotional deprivation, seeing the child etc. In the opening section I review current debates about decision making in child protection practice. I go onto explain the theoretical frame that I draw upon for this study, which is located within a psychosocial approach. I then feel it is important to revisit and make central what child protection work is ultimately involved in, i.e. the assessment of child abuse and that thinking about cruelty to children is intrinsically disturbing, usually contested and uncertain. I address a number of areas which are raised as themes from the analysis of the parenting assessments, and then the discussions with the social workers such as drift and delay in decision making for children who are at risk or who are in care. I explore emotional deprivation and the defences arising from anxiety provoked by the work.

The purpose of the literature review was multiple. I wanted to understand from the literature what was already known about why decisions for children at risk or in care go wrong. As I was increasingly interested in the emotional and unconscious factors, I wanted to learn from the literature what was already known in this area. I suspected that there would be an emphasis on the practical aspects of decision making, procedural failures or inadequacies, at the expense of a deeper understanding of how the pressure and experience of child protection work effects decision making. I highlight the gaps in the literature about the emotional and unconscious factors affecting decision making and have developed my research questions in response to this gap.

Decision Making in Child Protection Practice

In this section I identify research and literature which address issues of decision making in child protection practice. I look at contemporary studies to explore what is known about decision making in child protection in general. However, I have looked at this literature to see if any reference is made to unconscious processes underlying decision making, as the review of the literature has this as a key question.

Keddell (2014) undertook a comprehensive literature review looking internationally at the research or literature about decision making in child protection work. She wanted to understand the causes of variability in the response or interventions families experience and decisions made about children. This was a complex area with explanations at micro and macro levels, therefore she took an ecological approach to the review. Rational factors highlighted by the search are context specific including the policy context, cultural ideas, organisational context (which she evocatively describes as 'good' or 'wicked' environments). However, alongside these rational factors she does highlight the more irrational processes that can take place, such as 'group think' where practitioner's decision making becomes influenced by group processes which encourage agreement, and inhibits criticality and dissent.

International comparisons show that decision making is not equitable, as there is significant variance in decision making regarding families and children, and this raises interesting ethical considerations and the need for equity. Keddell explores the more irrational reasons behind the variance in decision making, such as the beliefs, meanings and constructions people hold about families within their specific social context. She found that there was little research based on real experiences of decisions, and generally research was not based on real life. The emotional aspects of decision making do get a fleeting mention, citing Platt and Turney (2013) but she does not mention unconscious reasons for variance in decision making. She does mention the importance of relationships and how this may relate to decisions but does not discuss these in depth.

Platt and Turney (2013) explore the variance in decision making, concentrating on researching the literature from the UK and elsewhere regarding the threshold criteria for social work intervention in child protection cases. They argue that a technical-rational approach to decision making is limited in effectiveness and a naturalistic approach should be taken, based on an understanding of the 'sense making' front line social workers do in their work. They highlight the importance of the individual workers' personal factors in decision making, highlighting the importance of heuristics, bias, pattern recognition, values, affect and intuition. They believe that intuitive processes are important but should be acknowledged, reflected upon and balanced with the rational aspects of decision making. Importantly for my study, they do not mention unconscious processes. They also look at decisions at the earlier stages of interaction such as initial assessments, where as my work examines what happens some years down the line.

Getting closer to my research study, Dickens *et al* (2016) undertook a more recent literature review of decisions for children on the 'edge of care.' They make international comparisons in decision making, particularly and most relevantly exploring the use of independent experts to inform decisions. They sent questionnaires to social workers in 4

countries getting a response of a 1000 returns. They asked about the meaning given to requesting independent expert reports and highlighted the differences between countries about how they think about the use of experts in care proceedings. They found that UK social workers were less likely to find experts helpful than in other countries. They also found that the court was used as a last resort, and there were many filtering processes which diverted cases being taken into care proceedings. However, this was a quantitative study which did not illuminate the emotional processes of decision making relevant to this study.

Taylor (2013), does consider the place of emotion in decision making highlighting that social work involves working with people at times of crisis, tension and stress. He points out that people in these crisis situations can feel fear, anxiety and may show hostility or distrust. Emotions should not be seen as entirely negative, but also as times of crisis which have the potential for change. Taylor stresses the central importance of the emotional content of decision making, and highlights the dangers of not acknowledging the significance of emotions. For example, Taylor warns against a lack of emotion, where emotional distance predominates and leads to dispassionate decisions lacking in empathy towards the client. He also argues that there is a danger in too much emotion, which leads to the worker feeling overwhelmed, and in danger of over-identifying with a person's problems. These two dangers can be overcome through engagement, empowerment and collaboration. This is meant as a helpful guide aimed at those in the first two years of their career. It is indeed helpful, however, it does not address the dynamics behind cutting off emotionally or becoming overly affected. Therefore, the unconscious processes or significance of the traumatising affects of the work are largely ignored.

Houston (2015) does address issues of the unconscious in reducing error in child protection practice, and calls for what he terms a holistic-rational perspective. A holistic-rational perspective is an antidote to the technical-rational, 'instrumentalist' approach taken in a managerial system, which places too much emphasis in following procedures. His concept incorporates the critical-rational, affective rational and communicative-rational forms leading to an enlarged form of rationality. His paper covers the irrational and highlights how unconscious processes can be thought about during good reflective supervision. In all of these studies the unconscious is reduced down to a concept of the irrational. There is no model of the unconscious offered.

Excepting Houston (2015), there is little in the literature about unconscious processes in recent years. The mainly insights into how unconscious processes affect decision making remains with the seminal studies by researchers such as Hughes and Pengelly (1997) and Mattinson and Sinclair (1979). I will review their work later in this chapter.

Unfortunately their insights seem to be long forgotten. Therefore my research seems to bridge a gap of much needed knowledge.

One last point, linking to my next section, is that research is rarely conducted through a strongly articulated theoretical lens. Most are ‘atheoretical.’ Taylor (2013) found that his research into assessments showed that theoretical models are rarely used. This study has a clear, explicit theoretical approach based on psychoanalytic and psychosocial concepts.

Theoretical Frame

This study sits within a psychoanalytic theoretical framework, in particular it draws on some classic Freudian concepts, such as projection, transference and countertransference. It is also heavily located within a Kleinian and the British post-Kleinian tradition, which is usually referred to as ‘Object Relations’. Melanie Klein and Wilfred Bion developed many of Freud’s ideas about the unconscious, linking psychic structures of the mind to early infant development. Freud, Klein and Bion are the main proponents of the concepts used to frame this study. Kleinian theory bases psychic structure on phantasy, her emphasis is on how internal structures get projected onto the external world. Object Relations places more emphasis on how external structures shape the internal world (Frosh, 1999) However, both Kleinian theory and Object Relations emphasise the development of the individual in relation to others and the environment. It is argued that the earliest necessity of the infant in their development is to seek a relationship with an other, usually the mother (or primary caregiver). Psychic base structures are developed within this dyadic context, which at some point becomes triangular with the introduction of the father. All subsequent relationships are informed by the quality of the relationship with the early care giver and subsequently, how the Oedipus complex is negotiated. Early experience of care lays down the foundations for future relationships. The key concepts are: Projection, projective identification, transference, countertransference, defence mechanisms, splitting, containment, reparation.

Psychoanalytic theory from the object relations tradition developed by writers such as Freud, Klein, Bion, Menzies Lyth, Britton and Steiner, is particularly useful in understanding and describing defensive processes arising from anxiety. The idea of ‘defence mechanisms’ arise out of a need to manage anxiety and from an avoidance of suffering mental pain. These are ordinary processes which we are all subject too. However, in cases of early parental failure defence mechanisms can become overly relied upon, stuck and problematic, thus inhibiting the person’s emotional development.

Conceptual Introduction to Bion, Freud and Klein

The reason for drawing primarily on the psychoanalytic concepts of Freud, Klein and Bion was to highlight the power of unconscious dynamics, as they are particularly important in relation to understanding emotional distress, anxiety, and the emotional impact of the work on the worker. Social workers are rarely provided with a theory which helps them to understand the disturbances of their work or entrenched human problems (Bower, 2005). A psychoanalytic framework provides an understanding of emotional deprivation in childhood and how problems such as deprivation and trauma can manifest themselves in adulthood. They are repeated down the generations (Faimberg, 2005). I will describe the main concepts used by Bion and which are particularly relevant for this research.

Containment is a concept developed by Bion (1967). The model for this is the way the mother helps her baby cope with difficult emotions. These emotions are projected into the mother (container) who processes them in her own mind and returns them in a more manageable form to the baby (contained). Over time the baby internalises the mother's capacity for containment. In social work terms it is the capacity to be emotionally receptive to client's feelings and to reflect on them before making decisions about action (Bower, 2012).

Reverie is related to the above process of containment as this is the state of mind of the mother in relation to her baby's communications. It is the idea that the mother has the capacity to take in the baby's communications, think about what the baby is communicating in a way that makes the baby feel understood. This allays the baby's fears and anxieties and is likened to the process of digestion. Thought is developed in a process of projection and introjection between mother and baby. However, Bion also thought that the baby necessarily required to feel some level of frustration as they developed their own internal capacities in order to develop thinking.

Internalisation/introjection is the process whereby the baby takes in their mother's capacity for thinking, developing their own embryonic mind in response to the processes of containment. The baby will eventually internalise (introject) a capacity for thought.

Nameless Dread/annihilation derives from the idea that babies experience their emotions very intensely, to the point where they fear for their survival. Physical discomforts such as wind or hunger produce terror and a fear of annihilation. You only have to be in a room with a crying baby for a short period of time to experience the intensity of this fear and distress, as a baby's cry can be unbearable. In instances where

there is a failure of containment the baby has no way of mitigating these terrifying experiences with enough good experiences of relief. Bion (1962) wrote about the infant reintjecting his own fear when the mother was not able to take this in, resulting in the internalization of a 'nameless dread.'

Bion's concepts, particularly that of containment, can be seen to be applied in Chapter 5 where I highlight the containing nature of the social work interviews. It is clear that the interviews acted as a way of helping the social workers come to terms with and think about the emotional experiences of the work.

In terms of using Klein's ideas, I find the concepts of projection, projective identification, splitting and defence mechanisms particularly useful to describe the unconscious dynamics which affect clients and professionals. They are useful concepts for understanding how internal processes are externalised and how unconscious factors affect the relationships around us, how we perceive these relationships and how defences against anxiety can impact on our judgement. For a summary of the meaning behind the psychoanalytical terms I use please see the Glossary section at the end of the thesis.

In relation to the research Freud's idea of transference is central. Transference, is considered as a projective process with primitive prototypes, i.e. early relationship models in the mind which are transferred from the client onto the social worker. A typical transference response may be an older female social worker being experienced as a maternal figure by a younger client. Maternal transferences are quite useful if understood, thought about and worked with, as it usually indicates emotional deprivation and the kind of help that some clients need. However, transferences can of course be negative. A client from an abusive background can experience the social worker as punitive, harsh and abusive. They can view them with hostility and huge distrust. When a child has been abused it is hard to regain trust in parental authority figures, represented as an adult by authority figures such as social workers, police, judges etc. Even when the social worker considers themselves to be benign and is trying to be helpful, this help can be rejected as controlling. Bower (2005) provides a powerful explanation of how help can be seen by some as the problem.

Child Protection Work

Writers such as Ferguson (2005), Cooper (2005) and Rustin (2005) all point to the emotionality of child protection work and talk of the highly disturbing nature of case dynamics. They point out that public inquiries into child deaths rarely look at the experience of the work for the social worker and what may impinge on their decision making capacity. Policies arising from these inquiries and which now guide child

protection practice tend to focus on a ‘rational, technical’ approach to decision making, at the expense of professional discretionary judgement (Munro 2011; Ferguson 2014; Ingram 2013; Houston 2015; Whittaker, 2015). The technical, rational approach promotes the view that if only good enough procedures are developed and adhered to, then the right decisions will be made. In contrast I place the nature of the child protection task itself at the centre of this study.

I call on writers such as Rustin (2005), Bower (2003, 2005, 2014) and Hughes and Pengelly (1991) in order to show how powerful unconscious processes effect decision making. If these factors can be understood and thought about, then a more holistic approach to decision making can be taken which is observant of the emotional impact of the work. This has been called ‘affective rationality’ by some writers (Rustin, 2005 and Houston, 2015) and it involves reflecting on the emotional impact of the work, as a communication about the underlying difficulties that the family faces, through a process of projective identification.

Drift and Delay in Decision Making

In addressing issues of drift and delay in the decisions for looked after children I focus on the findings of writers such as Beckett and McKeigue (2010), at research by Brandon et al (2006, 2009a, 2009b, 2010) and research lead by Ward et al (2006, 2013). These researcher’s works offer significant contributions in understanding the factors affecting decision making particularly in relation to delay. These writers identify structural causes for delay such as the way the care system is set up for short term placements, or the way in which court processes cause delay in decision making. It is only Beckett et al (2014) however, who hints at the psychodynamic reasons for delay in decision making. The emotional and psychological effect of delay, whether prior to removal or afterwards, on the child is described here.

“Developmental and behavioural difficulties were more evident amongst children who had experienced some form of maltreatment, often whilst professionals waited fruitlessly for parents to change. These were children who, at the end of the study, either remained living at home amidst ongoing concerns or had experienced lengthy delays before eventual separation” (Ward et al, 2006)

“A good parent would not keep a child in a state of anxious uncertainty for longer than was absolutely necessary. The longer the wait for a decision in care proceedings, the longer the child has to endure the anxiety of having no long-term security. And too long a wait can reduce the likelihood of security ever being achieved’ (Beckett and McKeigue 2010)

These two quotes encapsulate the risks of leaving children at home in abusive circumstances or leaving children in temporary, insecure care settings once they have been accommodated, alongside the impact neglect prior to coming into care has on the child. The first quote also highlights the emphasis social workers place on the work with parents at the expense of the child. Ward et al (2006) highlight the ‘double jeopardy’ of children removed too late from their birth parents, when they have already suffered harm, to be placed in temporary care where they are at risk of moving several times before a permanent home is found. They found that decisions were affected by factors such as: a lack of training about child development; a lack of knowledge about the long term effects of abuse and neglect; and little understanding of attachment theory (2006).

Perhaps the most vociferous and effective researchers in the area of delay for children in care are Taylor, Beckett and McKeigue (2003, 2008, 2010, Beckett and Dickens 2014). In 2003 Beckett and McKeigue undertook research which highlighted the reasons for delay as; ‘exceptional circumstances arising in the course of care proceedings, difficulties in measuring neglect, parents with learning difficulties, changes in circumstances, court timetable problems, care orders used as a means of supervision, changes of social worker, assessment issues.’ They found that in the cohort they examined, the court required proof, over and over again, that the children would suffer in their parents care before coming to a conclusion about the long term plan for the child.

Beckett has undertaken a number of subsequent studies into the track records of local authorities about their actual care for children, following the premise that a good parent provides stability and security for their children. They found that the average wait for a decision for a child involved in care proceedings is about 8-10 months and worryingly sometimes over 12 months (Taylor, Beckett and McKeigue 2008). They argue that good parents wouldn’t keep their child in a state of anxiety for longer than necessary and that this results in long term psychological harm to the child. Their studies don’t just look at the length of proceedings and delay in making decisions for children, but also look at the number of time children move placements whilst in the care system, and how long they are in impermanent homes whilst care proceedings are being undertaken. They describe the instability and psychological harm created by multiple moves to new placements, in addition to drift and delay as ‘system abuse’ and this ‘system abuse’ is a form of child abuse in itself, likely to result in long term emotional harm (Taylor, Beckett and McKeigue 2008). They also argue that professionals should not just be concerned with what happens to children in the future as ‘objects of concern’ during proceedings but should be concerned with what happens to them in the here and now (Beckett and McKeigue, 2010). Delay, changes of carers, and being exposed to a bewildering array of professionals causes long term psychological harm to them and contributes to long term problems with forming attachments.

In 2014 Beckett and Dickens undertook further research into the effectiveness of a new pilot scheme that undertook to reduce care proceeding court times to 26 weeks. They found that the pilot was successful in reducing timescales from a median of 49 weeks to 27 weeks. However, Beckett was concerned that quicker decisions about children may result in a compromise in justice for parents and they would not get a fair chance to prove that they could change. Despite this concern, he found that the same decisions were made for children, and that you can have reasoned judgement in that time and not compromise social justice for the parents. In fact many parents welcomed quicker decisions as having care proceedings with the threat of their child's permanent removal hanging over their heads was very stressful in itself.

The 'only disadvantage' Beckett surmised was the emotional toll that this level of decision making and progressing the work took upon the social worker. A point very relevant to my research and an interesting subject for further research. This toll is called the 'emotional labour' of the work. Beckett and Dickens highlight the sheer effort it takes to work concertedly in that way over the course of proceedings - and the qualities needed, such as 'being strong' 'robust' and 'having energy' (2014). They thought that the sustained effort to work in this way may prove exhausting in the long run, raising the fear that it would cause workers to 'shut down,' in response to stress. If they become shut down they may become emotionally cut off, providing the families in these circumstances with a distant, cold service lacking in empathy, removing the relationship element that can affect change.

Ward, Munro and Dearden (2006) wrote an important book called 'Babies and Young Children in Care, Life Pathways, Decision Making and Practice,' based on research which examined:

"...the relationship between the family circumstances, their life pathways and the different factors which influenced the decisions made by parents, relatives and professionals (Ward, Munro and Dearden, 2006)"

They looked at the circumstances of 42 babies across 6 Local Authorities, in order to identify why delay occurred either before they came into care or once they were in care. This was in order to understand the effect that decisions had on the long term outcomes and life pathways of the children. Delay and instability were identified as the factors, which negatively affected long term outcomes for children, although they also highlighted the negative effects of neglect and abuse before children came into care. They found unacceptable delay in making decisions for the young babies, citing a number of different factors. They highlight the delaying effect of legal concepts enshrined in the Children Act 1989 and UN Conventions. They viewed decisions based

on these concepts as complicated and finely balanced, causing delay in making decisions at court.

However, Cooper and Webb (1999) talk about impermanence being embedded into the structures of care, they also found that a large amount of disruption was already built into the care system. For example, they cited a chronic shortage of foster carer placements as explaining some delays in decision making, as pressures on foster carers and placements, delayed the decision to remove a child for as long as possible. This resulted in the ultimate removal of the child being unplanned or on an emergency basis (90%). Emphasis in the system was placed on providing short term placements with a view to returning the child home, with high numbers of children being returned home, only to be taken into care again. Ward argues that pressure to promote upbringing within the family of origin, together with incentives to reduce numbers of children in care, leads to practitioners not being able to recognise that there are a small number of parents who cannot look after their children within the timescale dictated by the child's needs.

However, Ward found that the main reason for delaying plans for children was the overriding concern in organisations to keep children with their families of origin. They would 'over exhaust' all possibilities in order to achieve this desired outcome. Even when children were eventually accommodated, their care plans were a return to their parent's care ('rehabilitation home' in the jargon of social work). Rehabilitation had to be tried, but it caused delay. As one children's guardian puts it,

"...but this particular mother had been known as a child herself in care to all members of the team, and they had put in vast resources [...] they were almost overly committed to the mum really" (Ward, 2006, p-88)

Ward, et al (2006) used this case to highlight how the relationship that the social worker had with the mother led to delay, and affected their decision making as they found it difficult to separate her interests and needs from that of the child's interests. This links to my own observations in Chapter 5, arising out of the interview with the social worker in a very similar case involving a young woman with a background of being in care. Ward warns that in these cases, special attention to the emotional pressures and dynamics needs to be given, as it is extremely difficult for social workers to focus on the child when the mother is so deprived.

"When the mother is very young and has herself been looked after by the local authority, it is very difficult to keep the best interests of the child at the heart of decision making. Practitioners may need additional support in ensuring that the child's needs are met (Ward, 2006)"

Ward, *et al* (2006) found that children's plans also become delayed due to courts putting off decisions in response to it being so difficult to prove that parents cannot care for their child, through the assessment process. They highlight conflicts in law between human rights and the rights to family life, and the child's right to be protected from harm. Given the emphasis on human rights it was necessary to offer time limited assessments to parents even when it was highly improbable that the child could return home. Time limited assessments provided 'extra proof' to all involved that rehabilitation home was not possible. Ward et al. (2006) suggest that perhaps decisions about children in these scenarios could be made with an additional assessment of the efficacy of what has/has not worked in the past. They argue that better information systems could inform care plans instead of merely repeating assessments. Ward et al point out that the human rights agenda has led to the seeking of the parent's wishes about their children even in situations of permanent removal. However, parents are likely to want to delay decisions because they are having to come to terms with the loss of a child and this is a painful process and they need to feel they have made every effort before they let go (this is particularly relevant to Cases A and B). Ward et al argue that there is a complex link between delay and instability in children's placements, as the longer children remain in care the more placements they are likely to experience and visa versa. They point out that avoiding a decision can have adverse consequences.

Ward et al. (2006) argue that delay for the babies in their study was caused because, almost all of the social workers believed that children should remain within their birth families, and as a result they worked with the parents at the expense of the child. This belief was reinforced by an organisational system that emphasised assessment and rehabilitation home once children were accommodated. Leading to children remaining in short term foster care and a lack of emphasis on long term planning.

Decisions were informed by rights and empowerment concepts, so emphasis on parent's rights overrode the needs of the child. The intervention, treatment or support offered to the parent was usually short term. Decisions concerned with an avoidance of creating dependency, rather than being caused by limited resources. Interestingly, for this study, they highlighted the use of parenting assessments as causing delay, due to overly optimistic recommendations about the child remaining at home when they were often removed later anyway. They cite fallibility in expert opinion as a factor causing delay.

Ward (2006) set out the implications for policy of their findings about delay for babies, making a number of recommendations about social worker's core training. Including understanding child development; the impact of abuse on children's emotional development; and knowledge of attachment theory. One of their recommendations supports the premise of my own research design, "Evidence of delays caused by repeated and unreliable expert assessments of parenting capacity should lead to some

reconsideration of their use. At the very least assessors should routinely receive feedback concerning the outcomes of their recommendations”. For the cases contained in this study, the feedback for the assessments I undertook were broadly, very positive and the recommendations found to be not overly optimistic. Many of the recommendations led to final Care Orders and adoption or permanent placement in kinship care settings.

Unfortunately, Ward’s study fails to fully explore the emotional dynamics behind decision making or the social worker’s experiences of the cases. In particular, it misses *what it is* that makes these workers preoccupied with the parent’s needs at the expense of the child’s. They highlight really important factors, which lead to delay, but these promote a superficial understanding of the difficulties in making decisions about children in care. It is important to understand these structural features, as they can be changed or mitigated in order to improve outcomes, but without an understanding of the emotional elements and what occurs ‘beneath the surface’ (Cooper, 2005) we will be unable to address the psychic defences and responses to the anxiety that the work provokes. Exploring only the structural factors, does not give a full account of the difficulty of the primary task. In addition, they reach a dubious conclusion that decisions about subsequent children in care proceedings could be made more bureaucratic via a paper assessment, without involving the parent, and that this would lead to quicker decisions about children. The dangers of this are an obvious dehumanisation of the process.

A better approach which involves intensive emotional and psychological support to the parent on referral to care proceedings is available in the form of the innovative approach of the Family Drugs and Alcohol Courts (FDAC). FDAC is a team of inter-professional practitioners, including judges, social workers, psychologists, addictions workers and therapists who offer support to parents with addiction problems (drugs or alcohol) on the point of referral to court. FDAC are specialist courts which have a more intense intervention approach. They have relatively high success rates with parents who have addictions, as they support them at the most crucial point in the change process i.e. when the child is 0-6 months (Bambrough, Shaw and Kershaw 2014). Therefore, if the parent has had a child removed due to their addiction problems and then has another child further down the line, this specialist intervention may be successful and is a humane way of undertaking assessments and intervening to help the parent change. If subsequent children were removed without this therapeutic intervention, and just through a bureaucratic exercise as Ward suggests, then justice would not have been done.

Other writers have commented on the dynamics of delay. Duncan and Reder (1999) describe this as 'assessment paralysis', where professionals become overwhelmed by making a decision of such huge importance. Beckett and McKeigue (2010) describe there being a psychological gradient in favour of delay, as it is easier to put off making a decision due to the anxiety it causes by pushing the anxiety into some time in the future. They argue that this delaying tactic is the 'line of least resistance'. Going back to Ward et al, (2006) they also found that there was delay before proceedings in part related to support services (e.g. addiction services) not being offered to parents in a timely way, in addition to delays in proceedings due to the legal process itself.

Delay - A Psychodynamic Perspective

There are many strengths to the studies I have looked at above, highlighting the structural nature of causes for drift and delay. However, these studies seem limited by the lack of focus on the emotional impact on the worker of making difficult decisions about children and the unconscious processes which may paralyse or confuse workers. There is a good analysis of the structure and extent of the problems. They appraise what is happening and speculate on the why, but there is little exploration of how these decisions become delayed from the social worker's point of view. The social worker's experience is lost in these studies.

In their study Cooper and Webb (1999) get closer to the social worker's experience. They undertook research into children in the care system within an inner city borough, where the care plans had become stuck. Their study involved looking at 80 children already in the care system whose care plans, and in particular the issue of Permanency had become significantly delayed. They paid particular attention to the experiences of those practitioners involved with the children. They examined the relationship between policy, practice and the independent dynamics of the cases.

They argue that decisions about children have become complicated by the effect of a postmodern outlook where no one person or body exerts overall control over the child's life. They highlight the diversity of forces and influences on decision-making, including the voice of the child. They argue that there are no simply defined 'looked after' children, but children looked after within their 'tangled, ambivalent and conflicted caring system' who the social workers then have to work with. Children's emotional experiences and relationships are complex, with children making attachments irrespective of whether the placement is termed emergency, short-term, long-term, or permanent.

The researchers frequently found that care plans entailed a choice between “disrupting a *de facto* fragile situation, which *was not planned for*, but to which the child has become attached, or abandoning this in favour of a well thought out but untried and untested option to which the child may have no emotional attachment at all”. Cooper and Webb use a case study, which highlights the child’s point of view, with him acting out his feelings of the initial abandonment by his parents with his subsequent carers. This following extract highlights dynamic processes involved in the social worker’s decision making, such as mirroring, splitting and projection. Importantly, they describe the state of mind of the child and carers:

Simon’s psychotherapist Janet Philips is particularly interested in the idea that impermanence is in the minds of the children who are subjected to it, a kind of borderline state, similar to that which we find in adults who we think of as exhibiting ‘borderline’ psychopathology; but also that ‘bridging placements’ and the other temporary or transitional care arrangements we create, may themselves have ‘borderline’ features, either as a response to the contradictory demands of caring for a dependent and damaged child, but only temporarily; or as part of a more ingrained mind state in the carers, or both; it is the meeting of these states of mind which is so problematic, and may give rise to a very fragile equilibrium in the total situation of the placement. (Cooper and Webb, 1999)

On a more practical level Cooper and Webb found that the factors involved in drift and delay were “cases unallocated through lack of staff or long-term sickness, review decisions made but not properly implemented, family finding getting nowhere, Form Es not completed, disrupted placements and disturbed children”. However, unlike Beckett (2010) who viewed delay as causing irreparable psychological harm akin to emotional abuse, Cooper and Webb argue that permanency may be a rather English construct, and that staying in foster care long-term without a decision about permanent plans, but with some continuing contact with their families may not be a terrible option for children at all. They argue that the system seeks out and comes to *it’s* own state of equilibrium and that cases have their own individual dynamic that not even the social worker has complete control over.

Webb and Cooper bring the experiences of the child, social worker and network to light and what is particularly relevant to this research is that they describe case dynamics from a psychodynamic perspective. However, I am critical of their argument about the status quo, which appears to be apologetic about drift and delay, as if it is inevitable in the system and rather dismisses the idea that impermanency causes psychological harm to children. I have always found that children are much happier when their futures are certain and they know where they belong. As I will go on to demonstrate, permanency can be achieved with the right amount of attention, emotional investment in the work and with

a good assessment. Like Beckett and Dickens say, it is the emotional cost to the worker that must be examined as the area of weakness in the system (2014).

The Primary Task of Child Protection Work

“The inadequate responses of individuals and institutions are, I argue, profoundly linked to the disturbing impact of what they are trying to manage” (Rustin, 2005)

Many reviews of social work intervention with children and research into decision making in child protection work fail to really get to grips with the complexity of the primary task. It is my assertion that effective research cannot be undertaken into this most difficult area of human experience without a deep understanding of the psychological causes of child abuse and a proper appraisal of what child protection entails i.e. the engagement with disturbing realities of the physical and emotional harm to children. Munro (2008) dismisses any attempt at defining child abuse as socially constructed in time and place. Although definitions may be influenced by beliefs stemming in time and place, this stance tends to disavow the real phenomenon of child abuse and does little to illuminate such an important, complex and enduring problem. It would be hard to argue in cases where children have suffered severe harm or death, that what has occurred is simply a construction. Therefore, I take issue with Munro and Dingwall et al (1983) who emphasise the relative nature and social construction of child abuse. For a depth psychology I turn to psychoanalytic ideas to illuminate the disturbing nature of child abuse.

Margaret Rustin writes emotively about the reality of what is at the heart of child protection practice in her paper about the life and murder of Victoria Climbié (2005). She leads us reluctantly through unbearable speculations about what Victoria must have been feeling and experiencing in the lead up to her death. The child’s perspective is very painful to think about and I found myself putting the paper down repeatedly, avoiding the horrifying realisation of the pain and terror Victoria suffered during her short life. In this way Rustin demonstrates powerfully why social workers defend themselves against the unbearable realisation and knowledge of child abuse, just as all humans do, as we have an understandable instinct to avoid mental pain.

She also describes how organisational bureaucracy can fit very well with this kind of defence, leading to ‘organisational mindlessness’. Rustin speculates about how much awareness of deprivation we can allow into our mind. She describes how the defences against recognising this reality involve severe distortions of the mind, citing Steiner’s concept of ‘turning a blind eye’ (1985). This is the process of refusing to see what is before your eyes, as to do so would cause too much disturbance. She also describes a

second defence employed against psychic pain, that of ‘attacks on linking’ as developed by Bion (1967). Thoughts and thinking are purposefully disrupted in the worker by the parent in order to confuse them and ‘put them off the scent.’ These two defences are most at play in borderline pathology. In a similar, sister, article Cooper describes the defence of turning a blind eye, as ‘disavowal’ a dynamic process describing when something is known about, but not known about at the same time (Cooper, 2005).

Citing Mattinson’s concept of reflection processes (1975), Rustin (2005) describes the unconscious mirroring between workers and client in the Climbie case, highlighting the level of deceit and dishonesty of the witnesses in the Laming inquiry as similar to the dishonesty of the Aunt. She explains that in borderline psychotic states, it is hard to tell between deliberate dishonesty and the confusion around truth. Therefore, the impact of the aunt’s confusion and distortion of truth could have invaded the minds of others in contact with her, particularly when there was a relationship and she was trying to get them to see things the way she saw them. She describes this process as ‘projective identification’. The worker’s thinking was taken over by parts of the Aunt’s madness and instead of questioning her belief system, they mirrored it. Primitive, infantile anxieties became mobilised in the workers instead of more adult capacities. Rustin asks whether there is a kind of training available to social workers that can help them to mobilise more adult mental capacities in order to cope with the unavoidable emotional disturbance of the work. She writes,

“Practitioners need to become mindful of their propensity to identify and counter-identify with extreme pain. This can be achieved by utilising affective rationality in training, supervision and consultation. In these contexts, affective rationality enables the professional to stand back, create mental space and examine his emotional domain of experience (Rustin, 2005)”

Anxiety and Defensive Processes

Like Rustin, Bower (2003, 2005) highlights the pressure placed on social workers by clients, affecting decision making through projection and projective identification. She describes the powerful emotional impact of the work on workers, who are bombarded by client’s projections. She describes how some clients need to get rid of unwanted feelings and states of mind and through schizoid mechanism of splitting, making others feel them instead. This can have an actual effect on the worker’s state of mind and in turn workers can identify with these feelings, really believing that they are inadequate, helpless, cruel or whatever is being projected. These schizoid types of defences are rigid and differ in quality to more flexible projective processes whereby the client unconsciously wants to communicate and seek containment of their feelings, in order for the worker to understand them and bring them to light. This type of projection is from a more depressive position and forms the basis for empathy. One defence is

located in paranoid schizoid position and another in the depressive position (Bower 2005, Page 12, Klein 1940).

Bower (2005) describes the problems inherent in child protection work, as it often involves seriously disturbed individuals with chronic pathological problems. She problematises relationships, which she says can be “*hostile and suspicious or superficially friendly*”. In reality there are often serious long term difficulties in the parent’s behaviour, involving abuse, neglect and involvement in crime and violence. These involve pathological defensive organisations, defences that then get re-enacted by the professional system (Britton, 1985, Steiner, 1987, Rosenfeld, 1971). In pathological families Bower describes an intense loyalty to the family, even amongst children who have been abused. The family see themselves as ‘protecting’ their children from a hostile outside world. Like ‘Ghosts in the Nursery’ (Shapiro et al, 1975), the professionals are the ‘intruders’, not the ghosts of abusive parental figures. Bower describes ‘overt’ or ‘subtle’ threats towards the workers, either through intimidation or threatened violence. Often difficulties only come into the open when social workers try to challenge the family’s view of themselves or their care of their children. When this happens workers will usually be subject to pressures which are hard to withstand, particularly for an individual worker, and is a reason that, “*Gross abuse can go unrecognised and unchallenged*”. (Bower 2005, Pg 157).

Bower, building on Freud and Klein, explains that another aspect of pathological defences is the cruel or sadistic superego. Pathological defences of this nature are usually formed by a mixture of projected aggression in the individual and the actual aggression of the objects (parental figures). This type of superego makes it exceedingly difficult to face guilt and responsibility. She states that “*feelings of guilt are often evaded by nursing a grievance or masochistic behaviour which replaces the pains of guilt with eroticised suffering*”. Awareness of these issues can give us a more realistic perspective on what we can expect from our clients and the difficulties they have in making change (Bower, 2005). Guilt is defended against by its outward projection, paralysing the worker who feels the guilt instead, through projective identification. It is likely that some of the cases in this study involved projections of guilt, disabling the social worker’s capacity to make decisions for children, and leading to the case becoming stuck. Unlike the social workers involved in the cases, I was able to take my feelings of guilt to clinical supervision in order to think about them in relation to the underlying dynamics of the case. In this way I was able to make more realistic assessments of family problems.

Emotional Deprivation and Defences

Of course, people are not born sadistic and cruel but aggression is developed and stimulated through emotional deprivation in early childhood (Joseph, 1982). It is important to understand how deprivation manifests itself in the relationships between people in social work. Angela Foster (2013) writes about the multiple levels of deprivation experienced by a female drug addict, capturing the dynamic processes in the organisation arising out of her treatment in a residential rehabilitation unit. She describes the unconscious defence, splitting, originating in the mind of the service user, and how this impacts on her treatment and affects the professionals around her (Foster, 2013). Foster describes how the staff team, including herself, collude with the woman's ability to split off the disturbed part of herself, which is actually in desperate need of help, in order to present a more healthy, 'transformed,' outward appearance, where she appears to turn her life around to become drug free. They respond to an idealised idea she projects of herself instead of engaging with the more painful, conflicted and self-destructive part of her personality, which she keeps hidden. This has devastating consequences as she commits suicide shortly after she leaves the rehabilitation unit. Foster explains that this splitting into good and bad parts of the self is a response to the pain and guilt associated with social failure, arguing also that women who get angry are stigmatised and marginalised rather than helped. The idealisation of motherhood critiqued by writers such as Welldon, (1988) and social expectations women face create the conditions for guilt, shame and feelings of failure, which reinforces internal self-destructive forces already present.

Woodhouse and Pengelly (1991) were also interested in exploring the theme of the pathological defences arising out of early emotional deprivation, and the resulting effects of the dynamic processes on decision making in child protection work. In their 1991 psychoanalytically informed research into the way relationships shape the world around them, Woodhouse and Pengelly examined the conscious and unconscious dynamics between clients and practitioners, as well as between practitioners and other professionals. They conducted an extensive action research study into the emotional aspects of child protection work. They were particularly interested in describing the specific nature of the child protection task, as they considered this central to understanding the emotional affects on the social worker and how decisions about children are made. They describe not only how practitioners are affected by, and respond to, their client's anxieties and defences, but also the way in which the specific nature of the primary task provokes what they call *primary* and *secondary* defences against anxiety. Woodhouse and Pengelly explain that these kinds of defences operate within each specific organisational setting, manifesting themselves in unique ways that have their own character. These defences include the primitive defences of splitting, denial and projection.

The researchers were interested in marital work with the parental couple and how it could be explored in relation to child protection work, because traditionally parents were seen in a parental light rather than from a marital perspective. However, they found huge difficulties in promoting this paradigmatic shift in thinking, as social workers were unable to stay focussed on the relationship work, allowing themselves to be constantly diverted by the immediacy of the child's safety when apparent child protection concerns arose. Woodhouse and Pengelly's view was that the child protection problems the children suffered or acted out were in fact displaced versions of what was occurring in the couple relationship, which the parents could not confront with each other. Therefore they found that child protection concerns were 'displacement activity' from the parent's relationship difficulties which couldn't be face by the couple.

Woodhouse and Pengelly found that there was an overall policy to keep children at home where ever possible, when support could supplement the care. Importantly for this study they point out that the decision to remove a child from their home was, '*a point of maximum anxiety*' in social workers and maximum tension *between* professionals, arousing strong feelings in everyone. Social workers particularly feared doing more harm than good.

"They could envisage that they would probably have to intervene, but saw the intervention itself as potentially heavy handed and persecutory rather than helpful: even a miscarriage of justice" (Woodhouse and Pengelly, p. 177)

Within a wider social context, practitioners reported feeling like a 'rubbish bin' and 'under siege'. They point out that social workers, often working with 'deficient parents' not only had the task of protecting the child, but also the expectation of making up for the parental deficit. As this was impossible, they felt like bad parents themselves, thus accepting the parents projections and becoming projectively identified with an idea of failing parents. Woodhouse and Pengelly described the way parents, when feeling impotent, become child-like and recalcitrant in order to make the social worker feel impotent as well. As a result of this dynamic, social workers were pressured to take up quasi-parental role towards the failing parents. Paradoxically, this is undermined in turn as the worker becomes identified with the inadequacy in the family. Woodhouse and Pengelly found that social workers in this difficult area of work, need no external accusations of inadequacy or wrong doing, as they were the first to blame themselves.

"Their professional self-esteem was undermined not only from outside but from within, from anxiety that they might be perpetrating the very failures of parenting that they were committed to making good"

Unconsciously, worker's defences become aligned with their clients and under these circumstances work is reduced to 'protecting children from bad parents'. However, workers identify with their clients and feel they are 'bad' themselves. Woodhouse and Pengelly call these 'basic' and 'aggravated defences', which do not accommodate a holistic view of the situation but leads to a reductionist defence.² This defensive mindset led to social workers chasing child protection concerns rather than achieving a holistic approach to the family's situation.

Despite these pressures, Woodhouse and Pengelly argue that the actual primary source of internal pressure for social workers in child protection work was the fear of having 'unacceptable and unmanageable' ambivalent feelings towards clients. Taboo feelings such as hatred and contempt towards parents who placed their children at risk, and who resisted efforts to help them were felt to be too dangerous to discuss openly, consequently they were left unacknowledged and unaddressed. One defence against the ambivalence inherent in the work was said to treat parents as 'wayward children' where the social worker could maintain feeling like a 'benign parent-figure'. They point out that a lot of the parents were vulnerable and immature, able to illicit a powerful appeal for being parental care themselves. Whilst some work of a 'nurturing kind' was needed it sometimes led to a collusive denial of the real adult responsibility of the parents, taking the focus off the child. Then, when the focus returned to the child, social workers may be plunged back into experiencing ambivalent feelings towards the parents again, into 'internal conflict and anxiety'.

Emotional Deprivation and Addiction

Bower (2013) links addiction to an unconscious enactment of something that can't be thought about, such as abuse, trauma or emotional deprivation. It is also thought to be an attempt to seek a feeling of 'containment' through the use of a substance, which cannot contain. In some cases the addict seeks states of intoxication, which lead to obliteration, a feeling of being 'out of it' in order to deliberately pursue mindlessness and dissociation. Pain and conflict is therefore evacuated from the mind, split off and denied. Bower (2013) and Hyatt Williams (2002) both point to a 'strong suicidal current,' in addiction where aggression towards internal phantasy figures, (usually parental figures) is turned inwards, leading to self-destructiveness. It involves the destruction of a feeding relationship involving an actual 'other', who has to be depended upon. Being dependent on an 'other' outside of your control can be particularly terrifying for addicts, as they have may have experienced catastrophic parental failure in their early lives. Instead of trusting an 'other' for their needs, the addict turns towards the substance, which is under their control and can be procured at any time. Therefore it becomes a much more trusted, reliable object. However,

² Menzies Lyth highlights in her seminal paper about nurses (1970)

ironically Hyatt Williams (2002) points out that it is actually a choice of an unreliable object for containment, as the substance of choice eventually leads to psychic disintegration and degradation.

For Bower, addiction is rooted in a psychological problem relating to early emotional deprivation, abuse or trauma. The effect of the addict's behaviour is devastating to those around them, they attack relationships and project powerful feelings of rage and blame onto others. Children of addicts suffer hugely, often being invited into a hopeless dynamic whereby the parent looks towards the child for rescuing and parenting, leaving the child's development rarely attended to (Youell, 2013)

Foster (2013) argues that many women with addictions are, multiply deprived and abused and they enact this by imposing 'deliberate self abuse' and deprivation on their bodies, producing a relief from pain and anxiety. This sadomasochistic treatment of their bodies is then also acted out in overly harsh and punitive relationships with organisations and professionals, adding to a situation where recourse to drugs offers a psychic retreat (Steiner, 1993). She quotes Emmanuel's model of triple deprivation: Firstly the person experiences deprivation and abuse in early infancy through parental failure; then develops crippling narcissistic defences in response to the failure, which in turn leads to the re-enactment of abuse and deprivation in later relationships. Further, the 'system of care' then repeats this abuse and rejection. Workers are subject to powerful projections and projective identification of the emotions that the client cannot tolerate. The worker is made to feel psychic pain and a range of emotions such as hopelessness and despair. This leads to rejection by the professional and 'colluding with the clients need to make them fail'. Foster proposes further elements to Emmanuel's model, a fourth dimension of deprivation i.e. the inter-generational nature of abuse, and a fifth deprivation is repetition and confirmation in societal responses. Inter-generational abuse is explained as a way of women exerting control over their babies as a form of self abuse, by projecting into them the awful feelings that they themselves had as children. Dissociation protects the mother from the pain of recognising what she is doing to her child and this allows the abuse to continue.³

Seeing the Child

Lord Laming raised the question of 'seeing the child' in his Inquiry into the death of Victoria Climbié (2003 pg. 238). He found it unfathomable for social workers to have missed the suffering and abuse that was experienced by Victoria. Suffering that he described as 'staring them in the face'. His strong recommendations about the need to observe and talk to the child led to a national change in child protection procedure,

³ We see dissociation operating most vividly in the case study involving Lee (Chapter 5).

where every child had to be seen, alone, during the initial assessment. However, there was little enquiry or curiosity about the inherent difficulties in seeing, assessing and determining child abuse in his report. In particular there is no consideration of the disturbing nature of the work and the unconscious dynamics at play. Laming's inquiry echoed the public outcry and tended to blame and berate professionals rather than make a careful exploration of the nature and difficulties of the work (Cooper, 2005, Ferguson, 2005, Rustin, 2005). In his article addressing the Laming Inquiry, Andrew Cooper (2005) points out the difficulty in *wanting* to see the child and in particular the child's suffering;

"This is the continual and perfectly understandable wish on the part of workers to believe that what they are being presented with is not a case of child abuse. Because accepting that it is, or that it probably is, pitches them into immediate personal engagement with conflict, emotional pain and the welter of difficult feelings and responses, [...], It is in fact only human not to want to be obliged to enter this territory" (Cooper, 2005)

Dingwall (1983) reiterates the fact that it is inherently difficult to assess the phenomenon of child abuse, pointing out the huge variance in self reported abuse by individuals as adults and the actual number of recorded child abuse incidents. He argues, 'child abuse' is a social construct subject to changing interpretations over different generations and social contexts.

Ferguson's (2014) research about what actually occurs on home visits between social workers and families, highlights problems with social workers spending time alone with children. He explains how difficult it is to see the child alone when workers are subject to an array of differing pressures. These pressures include high caseload, together with tight timescales for assessment, parental aggression within the home, and a lack of playfulness and confidence in communicating with children. He found that workers continue to spend the majority of time with the parents, approximately 70% although this figure may also include seeing the child with the parent. He emphasises the need for social workers to have skills to communicate with children and points out that when they do, therapeutic relationships are formed and change can occur. Ferguson also describes a need for understanding the more hidden and unconscious aspects of the work, using psychoanalytic ideas to understand what he calls 'pathological communication'. Using Mattinson's (1975) theory of reflective processes, he hypothesises that social workers may mirror the disgust and neglect the parent feels towards their child, by neglecting to see them or feeling repelled so that they do not want to go near them during home visits. He raises the possibility that parent's purposefully elicit disgust towards the child by leaving them to smell and be dirty, in this way defending against a closer examination or relationship forming between social worker and child (this occurred in the Baby P case). He likens the idea of being in a

relationship with a very aggressive parent, to a hostage situation, like in the Stockholm syndrome where captives identify with the captor in order to placate them. This leads to an identification with the aggressor.

Brandon et al and co-researchers (2005, 2007, 2009, 2012) conducted a series of investigations into the findings of serious case reviews over many years, comparing and contrasting the themes and patterns across 4 periods of time; 2003-5, 2005-7, 2007-9 and 2010-12. This provided longitudinal insight into reoccurring themes in what goes wrong in cases where children are seriously harmed or die. There were strong reoccurring themes about the social workers being overwhelmed by the chaotic nature of the families and this 'enmeshment' being replicated by the organisation.

"Overwhelmed practitioners formed a theme in the 2005-07 study [...] where the chaos, confusion and low expectations encountered in many families were frequently mirrored in the organisational response. The families' disarray was often reflected in professionals' thinking and actions so that both families and workers were overwhelmed and failed to see or take account of the needs of the child. This also occurred in some serious case reviews where the child was also 'lost'. We pointed out that practitioners who are overwhelmed not only with the volume of work but also by the nature of the work will struggle to think, understand, make good decisions and do even the simple things well. It is arguably unhelpful to describe and think of the complex matters of relationship and professional judgement as simple" (Brandon et al, 2007)

This mirroring of the family's psychodynamics led to the 'invisible child' becoming 'lost' (2007, Pg 40). Brandon et al coined the term 'toxic caregiving environment' in their findings about the nature of the family's problems, which they found usually included domestic violence, mental illness and addiction (Sometimes known as 'toxic trio'). Families were overwhelmed and had little support. They describe the mirroring of chaotic behaviour by the organisation in response to the dynamics of the family, referring to Mattinson's concept of reflective processes. Reflection in this sense means that social workers identify with and mirror the families patterns of behaviour. This pattern of chaos made it difficult for social workers to 'see and understand' what was going on in families, or accurately gauge the risks of harm. Alongside dealing with the dynamic affects of chaotic families, workers also avoided making negative judgements and desired to see parents in a positive light and so the child's reality became lost or invisible.

The theme of the 'invisible child' is linked to social workers reluctance to connect with or even touch the child (a major theme raised in the interview data set out in Chapter 5).

“Children were missing or invisible to professionals in a number of ways. They include young people who were hardly consulted or spoken with, siblings who were similarly not engaged, young people who were not seen because they were regularly out of the home or were kept out of sight, non-attendance at school, young people who absconded, ran away or went missing and children who chose not to or were unable to speak because of disability, trauma or fear (Brandon et al, 2009)”

With these difficulties in engaging with children in mind, it seems vitally important to know why this occurs from a psychodynamic perspective, and based in an understanding of the social worker’s real world experience.

Harry Ferguson’s new research (2016) aims to explore the deeper dynamic reasons why children become invisible during home visits. He accompanied Social Workers out into home visits, conducting ethnographic research into the what occurs between social workers, children and parents in real time. He is particularly interested in the emotional dynamics, which lead to problems in child protection work and highlights one factor (amongst others) as the intensity of work. He also looks at the organisational factors such as too much paperwork, not enough supervision etc. He uses psychodynamic, psychosocial, systemic and cultural theory to understand the ‘invisible child’ (Ferguson, 2016). Although his research is incomplete one paper he has written so far concludes that dissociation can occur, where social workers become emotionally and spiritually absent in response to hostility, or bureaucratic pressures. When workers are ‘unheld’ by the organisation the child and family can become ‘unheld.’ Ferguson pessimistically suggests that rather than this being the exception to the norm in practice these lapses can be part of every day practice.

Seeing the Child and the Link to Oedipal Dynamics

One further theoretical point highlighted by Woodhouse and Pengelly (1991) about why the child may become invisible is the idea of ‘triangulation.’ They point out that the marital couple is caught up with two internal figures based on aspects of their own parents. Marriage and having children reawakens feelings from their own childhood, for good or bad, making the transition from two to three difficult, even ‘sometimes hazardous’;

“Triangular configurations are ubiquitous, and the dynamic forces they generate exert a powerful influence on human interaction. Third parties, actual or alive in phantasy, can undermine personal relationships” (Woodhouse and Pengelly, 1991)

This difficulty in managing threes and the resultant Oedipal problems may link to difficulties in seeing the child and a propensity to ‘turn a blind eye’ (Steiner, 1985), as one part of the oedipal triangle is not recognised in a collapse of the usual boundaries.

Britton offers further insight into how these underlying Oedipal dynamics in the family become re-enacted compulsively in the relationships between the family and social work professionals, where as he puts it, the ‘cast changes but the plot stays the same.’ Britton argues that little change is mobilised unless the unconscious dynamics are thought about and their psychic meanings understood (Britton, 2005). In this way it could be argued that the child protection system needs to offer a model of containment which makes up for this early failure in the parents, towards change within an emotional developmental framework. Containment is necessary if change on a psychic level is to be made possible.

Gaps in the Literature

What the review of the most recent and past literature shows on decision making in child protection practice is the lack of depth attributed to the lived experience of the social worker and the rarity of any exploration of the emotional and unconscious factors affecting decision making. Decision making is usually considered as a rational process, whereby if A is done then B will follow. None of the enquiries into child deaths ever explore the social worker’s experience or the emotional factors involved in the work.

Ferguson (2016) is the most recent researcher trying to examine the emotional and unconscious factors involved in child protection work, although this is into what happens in real time face to face work and he does not look specifically at decision making. His understanding of the impact of aggression (overt and covert) on a social workers capacity to undertake their work, particularly in relation to home visiting and seeing the child is a particular strength of his work. He also highlights the lengths some parents may go to to hide their abuse, in Baby's P's case making the baby an object of disgust which would deter the social worker from making a closer examination of the child for injuries.

However, I would suggest that his analysis of unconscious factors is slightly superficial by his limited use of psychoanalytic theory. His psychoanalytic insights are based on discussions with and self-reporting of the social workers (Ferguson, 2016). There is no discussion of transference, counter transference, projection or projective identification. Ferguson does not report on his own subjective experiences and the emotional intensity of the work he seeks to understand is somewhat deadened in his descriptions of what occurs. He does acknowledge the emotional pressures but he does not describe feeling them himself. As a practitioner undertaking a professional doctorate my experience tells me that the emotional impact of child protection work affects us in very powerful and destabilising ways. The intensity of the work and overt or covert threats of hostility and aggression can disturb us deeply and stop us from thinking. I have been paralysed by

dynamics and have an empathy for social workers on the receiving end of aggression. Ferguson does highlight these dynamics in his research but they are marginalised as he has never experienced them himself. Therefore his sympathy and insight is limited.

Ferguson's analysis also lacks a complete appraisal of the kinds of disturbances and states of mind people we work with can project. For example, my research looks in depth at the emotional deprivation in the parent, the impact of self destructive behaviours and the relational difficulties people involved in complex child protection matters exhibit. He also fails to privilege the primary task and how the disturbing nature of child abuse can be disavowed by parent, family, worker and organisation.

Given the lack of research into the emotional and unconscious factors affecting child protection work, this study seems important and timely. It may go some way in helping us to understand the factors that make decisions go wrong and in that way, suggest ways of practicing that can support the emotional needs of the social workers.

Research questions

Having reviewed the literature and identified the gaps, I will outline my research questions. I began the research with some wide, overarching research questions. I mainly began by evaluating the work I did with families to see if it affected outcomes for children. This exploration highlighted themes common to families in child protection procedures. However, as the research developed, and as highlighted by the literature review, it became clear that the most important theme under consideration was the emotional impact of the work on decision making and the role unconscious processes played in influencing social worker judgement. Therefore, the main focus became about the emotional and unconscious factors involved in decision making.

Research question: What are the emotional and unconscious factors involved in child protection decision making?

Subsidiary research questions:

- a) What are the dynamic processes involved in child protection social work, including cases that have become 'stuck'?
- b) How can common themes and patterns across the families be characterized?
- c) What emotional impact does child protection work have on the social workers involved?

Summary

What emerges from the literature is that the relevant ideas and influencing factors affecting decision making for children include: A need to define and privilege the disturbing nature of the primary task; The emotional and psychic difficulty of assessing child abuse; Problems with seeing the child; The various structural and unconscious causes of drift and delay.

In this literature review I have introduced a number of writers who have undertaken important research into the difficulties of making decisions about children at risk of abuse or who are in care. They provide the background context for the issues involved in child protection work. Some writers highlight the gaps in our understanding about the emotional and unconscious processes in decision making, which I hope the particular research focus of this study will go some way to address. In this area of practice it is important to introduce the perspective of the practitioner in order to understand what it is like being a social worker responsible for making complex decisions. As highlighted above this is usually absent in the studies about decision making. I will explore this issue in depth in Chapters 4 and 5.

2. Methodology

"We can only observe the phenomena that occur near or inside the experimental apparatus and the observer himself is the most important part of this apparatus" (Albert Einstein, quoted in Devereaux, 1967).

Introduction

This is qualitative research study based on an interpretive, hermeneutic approach. It is underpinned by a recognition of the unconscious processes at play on the researcher and the researched. A hermeneutic approach is interested in how we interpret the world and how we attribute meaning to what we think we know (Gomm and Davies, 2000). It is usually associated with qualitative methodologies, whereas positivism is associated with quantitative approaches. I use an interpretive approach to make sense of the retrospective data I collected when undertaking parenting assessments in Part One of the study and to understand the effect of unconscious processes on decision making in the interviews with the social workers in Part Two of the study. I have used this approach and the methodology in order to answer the research questions posed. A qualitative approach is more likely to highlight processes and the psychodynamic underpinnings of decision making in child protection practice.

The study also describes the lived experience of social work practitioners. The stories the social workers are encouraged to tell about their experiences are vivid, rich in description and illuminative of the emotionality and unconscious processes of social work practice. I place the exploration of practice experience and the relationships we have with our clients at the heart of the research endeavour, in order to develop new knowledge about the unconscious processes effecting decision making. This also addresses one of the research sub-questions about what it is like to be a social worker in complex child protection cases. The study uses case studies to capture the feel of the social worker's experience. Case studies are a traditional way of describing experience and practice and capture the case holistically, revealing often hidden connections between cause and effect.

In this methodology chapter I will explain the rationale of the study, the underlying epistemological assumptions, describe an idea about reflexivity which is based within a psychosocial framework and argue that unconscious processes and affect are indeed real and legitimate phenomenon which require exploration through research. I will also describe the research methods and design which aim to answer the research question about emotional and unconscious factors involved in decision making. The ethical

dilemmas are described in detail and thumbnail descriptions of the cases is provided for the readers ease of reference.

Rationale

The initial aim of the research study was to evaluate my practice and to explore the outcomes for the children I had been involved with as a independent parenting assessor. This was with a view to learning lessons about what works best and to improve my practice. However, as the research went along I became more and more interested in the emotionality and inter-subjectivity of child protection work and the psychodynamics arising from unconscious processes and their impact on decision making. It seemed important to explore and understand how unconscious processes affected decision making in the social workers that I knew, as I was increasingly aware of the unconscious processes impacting on and arising in me, and their effect on my decision making. My awareness grew through attending a post qualifying course at the Tavistock Clinic, undertaking a personal psychoanalysis and arranging clinical supervision for myself. I thought this was a hugely important and rarely explored area of child protection practice. I had unique access to social workers who knew me and may open up to me about their experiences and I had the advantage of knowing the cases and therefore more likelihood of being able to develop a shared understanding between us about the difficulties involved in the work. The overarching motivation however, was a curiosity about what had happened to the child since my involvement. These conjectures involved many hopes and fears.

Using Psychoanalytical Paradigms and Reflexivity

I chose qualitative methods to undertake the research subject as subjectivities and relationships cannot be researched easily through quantitative methods. Social work is about relationships, which are its 'ontological concern' (Gould, 2006). I particularly chose psychoanalytically informed methods in order to explore what occurs 'beneath the surface' (Cooper, 2005, Clarke and Hoggett, 2009). As Gould (2006 page 1) points out social work research is not interested in prescriptions only but about human relationships which are complex, problematic systems. Briggs (2005) argues that psychoanalytic theory opens up an often marginalised aspect of social work study, i.e. emotionality and intersubjectivity. Froggett and Briggs (2012) describe psychoanalytically informed practice near research methods as having 'thick description, intensive reflexivity, and the study of emotional and relational processes' (p.1).

Researching the *process* of relationships has two implications for improving social work knowledge; the emotional impact of the work on the worker and how these affect decision making, and then the organisational implications of such an understanding. These relational factors can also provide a different perspective on social policy. Wendy Hollway (2000, 2009) is at the forefront of methodological and epistemological developments in psychoanalytically informed qualitative research in the social sciences. She has brought a psycho-social approach to research methodology where knowledge is drawn from both the sociological and psychological paradigms. She argues that the 'evidence based practice' movement dominant in social work education and research at the moment 'imposes a paradigm for what counts as legitimate evidence that is external to the practices and ways of knowing of many professionals who are now required to evaluate their interventions', driving a wedge between professional experience and research.

Hollway (2009) argues that there are epistemological and ontological grounds for a psychoanalytic paradigm in the social work context. She argues that the researcher's subjectivity can be reflected upon as a way of knowing. Reflection provides an understanding that can help us to articulate the participant's experience and subjectivity in knowable ways. She developed the idea of the researcher as an 'instrument of knowing' introducing the idea that transference can be known about through the subjective experience of the researcher. This way of knowing is biased toward our interest in meaning, rather than quantifiable outcomes and she argues that these methods are better suited to capturing the ontological concern of social work, as the object of study is the complex nature of human relationships. She critiques 'evidence based practice' as not having the capacity to deal with the complexity of real cases and practice experience.

When analysing data Hollway (2000, 2009) argues that it is important to keep 'the vitality of the meaning' intact. She was particularly interested in how anxiety and unconscious processes affect what the research participant will reveal or not. She highlighted the important meaning behind pauses, unspoken words and emotional tones can reveal about the unconscious meanings being communicated. She defined the participant as the 'defended subject' where anxiety provoking topics may be avoided or glossed over by the participant (Hollway, 2009). Clarke and Hoggett (2009) extend Hollway's use of psychoanalytic and psychosocial ideas in research. They argue that the participant and researcher cannot only be considered as 'defended' and that other psychoanalytic concepts may be at play. They liken the research concept of 'subject positions' to the psychoanalytic concept of 'projective identification.' Projective identification is a central concept I will use to understand the problems in decision making when working with very emotionally deprived adults or children.

Clarke and Hoggett (2009) also argue that there are different kinds of affect, not just anxiety as Hollway and Jefferson (2000) posit. There are feelings of fear, excitement, boredom, etc. In the interviews with social workers I found that excitement could be followed by profound sadness, and a deeper connection with the pain and tragedy behind the case which could move me to tears (Case K). Becoming emotionally moved by the story in clinical terms means that the real tragedy behind the case is being thought about and not avoided, for example, by a manic defence indicated by the excitement and inappropriate laughter of the beginning stages of the interview. Horror and disbelief were communicated in a different interview (Case F). Anger and guilt and then the description of trauma in another interview (Case J). All of the interviews were intense emotionally as the social workers knew that I would understand their experience and opened up to me on a deep level.

Reflecting on what is conscious and unconsciously communicated in the interview is the emotional work of research (Hochschild, 1983). Counter transference includes reflecting on the emotional charge of the interview, the different feelings and intensities evoked in the researcher and researched. During the interviews with the social workers I noticed moments where things deepen, realisations between us were reached, and a shared understanding seemed to occur. However, there was also affective sharing, through the expression of anger, grief, trauma, excitement, sadness, tragedy. Emotional attendance, the emphatic stance I took, the way I survived strong emotional projections, offered containment. This containment was able to shift the interviews along, where complex situations could be faced, felt and then thought about (Bion, 1962), In this way the interviewer's 'reverie,' i.e. my attendance to the emotional aspects of the work and the unconscious or semi-conscious communications, helped to digest the experience and think about it, creating meaning through dialogical processes. In this way the interviews provided a process for deep reflexivity through attending to the conscious and unconscious communications, using countertransference responses to inform reflection and aid thought.

Giami (2001) has written a very important article describing transference and countertransference and how these psychoanalytic concepts can be applied to qualitative research methodology. Transference describes the model of a prior relationship (usually parental) transferred to the therapist/researcher by the patient /research participant. Countertransference is usually what is considered to be the reaction of the analyst or researcher to that transference. However, Giami, (like Freud with the analyst) argues that countertransference includes what the researcher brings to the encounter. This includes the unconscious reasons for the object of study. In research methodology involving countertransference there is a recognition that unconscious and subjective

processes inevitably occur and there can never be any 'positivistic' objective, neutral position outside of the knower. Countertransference is a reflexive attitude of the researcher where the unconscious is made conscious through a process of reflecting on our emotional responses in order to understand the unconscious communications of the research participant. This mirrors the assertion I make about the use of countertransference in social work assessments to offer containment to the family.

Giami, (2001) argues that transference and countertransference are ways of understanding and interpreting the world in which we inhabit, and will inform how we see and interpret our world. It can include the way we approach the interpretation of research data. Therefore, the Objective is always viewed through the Subjective. He argues that positivistic methodologies derive from a defensiveness against an anxiety about the subjective positioning of the researcher. Devereux (1967) was the first researcher to introduce the idea of countertransference to behavioural science research. I used a number of practical methods to promote reflexivity in myself as the researcher. Firstly, I reflected on the unconscious meaning of the research during my own personal psychoanalysis, linking it to a move away from re-enacting my own childhood trauma and abuse, to a position where I could reflect on the meaning of the work to me. This was a deeply personal process of reflexivity. In this way the research came to symbolise my emotional development and a freeing from the identifications from childhood which engaging in child protection work partially was about. Secondly, I took my assessment work to clinical supervision, where I engaged in reflections on the cases in a professional, clinical setting with a senior clinical social worker/psychoanalytic psychotherapist. These two processes worked side by side for a long time.

Reflexivity was used in the undertaking of the interviews with social workers. I recorded the feelings and reactions I had prior to the interviews, capturing hopes and fears relating to what might have happened to the children and parents since my involvement. During the interviews I noted my emotional reactions and took these reflections to a research seminar where I reflected with a group of fellow research students on the meanings of what I found. I read out extracts of the interview material to a seminar group which provided me with different interpretations and meanings. This particularly helped me to gain insight into the unconscious role I held for the organisation, something that was hard for me to think about as a practitioner involved in the case material. It also raised issues about power differences, social and policy context, the use of language and words chosen, and the underlying meanings in cases. It helped with the blind spots we all have in our subjectivity (Urwin and Hollway, 2007, 2015).

How We Know What We Know, Truth and the Limitations of Our Knowledge

This research study falls within a critical realist tradition, which acknowledges that there is a world outside of us that can be known about, and where social phenomena have an existence in their own right, outside of the knower. Therefore, what we know is not just imagined but based on empirical evidence which can be shared with others. There are also power structures external to us, which affect our experience of the world and which we internalise. However, because it is from a hermeneutic, subjective position this ‘out there’ can only be perceived through a particular set of beliefs and invisible structural assumptions. These assumptions can be linked to structures of power based on class, gender, ethnicity, sexuality etc. It is argued that questioning the origins and basis of our knowledge in a critical way is of central importance in research (Alexandrov, 2009, pp 31) Alexandrov makes the important point of distinguishing between facts and interpretations, as our perception of the world is mediated by our assumptions about it (values, beliefs, unconscious fantasies, prejudices and biases). Therefore, we could in theory only see what we expect to see i.e. confirmation bias. Alexandrov warns against a reification and distinguishes between ‘primary’ and ‘secondary knowledge.’ Reification elevates human made assumptions about the world as facts, transcendental to human construction and outside of human authorship. Therefore there needs to be a process whereby the researcher interrogates their interpretations (interpreting the interpretations) called ‘double hermeneutics.’ In this research study the researcher achieved this through the use of reflective seminars, the use of an external clinical supervisor, the presence of the doctoral supervisor, and through checking out with the interviewee about their meaning. This promoted a high level of critical reflexivity by researcher.

Establishing a foundation for a shared understanding of truth is a problematic and much debated concept in social science and social work research. From a scientific positivistic tradition, it is widely held that phenomenon can be described independent of the knower’s influence. Truth is considered to be based in objective reality rather than a subjective position. A subjective position is considered to be of a lower standard of factual veracity than the objective establishing of facts. These descriptors originate in very different grounds from the hermeneutic psycho-social approach. The hermeneutic and psychosocial approach privileges and respects subjective knowledge. A subjective position would argue that we can only know anything from our subjective point of view.

In the qualitative research tradition reality is a contested ground. Reality is constructed prioritising the perspective attained and validated through practice. Validity is therefore

attained though an idea of consistency and internal logic rather than how what is seen corresponds to the objective world. From a qualitative tradition validity can thus be considered through the ‘coherence criterion’ (Alexandrov, 2009 pp 34). This also links to the decision to use Case Studies, as I argue that they provide a fidelity to the experience of social work practice. Kvale argues for a “dialogical conception of truth, where true knowledge is sought through a regional argument by participants in a discourse.” (Kvale, 2002, pp 305) This is described as ‘communicative validity’ where other researchers can rely on what is presented for their own research, as it communicates a truth about the practice experience.

Bhaskar argues that this is a more negotiated truth, arrived at from the limitations of our subjectivity, within a sociological framework. He called this “critical realism.” (Bhaskar, 1975). This epistemological position acknowledges that our understanding of reality is partial, but that nevertheless we are able to describe people’s experiences within the social world. These experiences are seen through the mediation of structures such as gender, class, race etc. This stance is compatible with my study, which aims to examine the unconscious processes inherent in child protection work, therefore privileging the subjective world but also acknowledging that there is a world out there that is knowable and which can be described. In this epistemological framework truths are partial, negotiated, based on perception and there can be multiple truths.

Using Case Studies

Initially I was going to present the themes from Part One (analysis of the retrospective data) and Part Two (Interviews with the Social Workers) of the research as the findings. However, I eventually decided that presenting the themes through three vivid case studies was more in keeping with the ontological concern of the study and provided more fidelity to the experience of social work practice which is at the heart of this study. Stakes (1994 pg 236) states that the case study is not a methodological choice but a choice of object to be studied and we chose to study the case, which can be in a number of different ways. For example, he compares the study of a child by a physician and a social worker; the doctors studies the child as the child is ill whereas the social worker studies the child as if he is being neglected. He describes that the child’s symptoms in each case are both qualitative and quantitative. However, the doctor’s record will be more quantitative, whereas the social worker’s more qualitative. The case study has a long tradition in social work research and education. A case study can capture the complexities of practice and the description of a case provides a ‘tacit, working knowledge’ rather than the ‘definitive truth’ (Greenwood and Lowenthal, 2005).

Development of Reflexivity, Containment and the Organisational Setting

Froggett (2002) describes reflection as the capacity to remove oneself from the common sense of the external world where the mind becomes the container in which to engage in an internal process of thinking thoughts and refashioning ideas. This is an interactive and iterative process which is externalised again, and where inner and outer experiences are connected. Froggett argues that it is the failure to contain anxiety in the organisation and the lack of a containing environment and an inability to contain the projections of its members that leads to fragmentation in thinking. It is the integration of *thought* and *feeling* which is a fundamental to reflection. Therefore thinking in social workers and their organisations can only be achieved with the right quality of environment. Sadly from my own experience of social care organisations containment is rarely provided and organisational mindlessness (Rustin, 2005) prevails. However, containment, and the integration of thought and feeling, can be provided by reflective supervision which can lead to the process of 'reverie.' Bion's approach to the issue of *knowing* (K) is based on the integration of emotion and thought through an experience of containment which is only partially based on dialogue (Bion, 1967). The psychoanalytic situation relies as much on space, time, setting and receptivity as much as cognitive processes. It is deep realisations about oneself through reverie which lead to emancipation.

Insider Positioning

The initial motivation for this study was to undertake a process of evaluating my own work and the outcomes for the children I had undertaken assessments on in order to improve my practice. Ian Shaw (2011) describes this evaluative process as an integral part of social work practice, undertaken by social workers in their 'day to day work'. Shaw explains that the position of evaluators in practice is to remain on the borders between practice and research; 'outsiders on the inside'. (Shaw, 2011, p 8-9). He argues that as social workers we operate from our 'thinking as usual' position and to counteract this an evaluative approach can promote a critical stance on the work. 'Evaluating the process of practice is practitioner evaluation.' (p.114)

I was part of the broad professional group that was being researched; as I was (and still am) a children and families social worker. However, as an independent social worker I did not 'belong' to the organisation and had an outsider status compared to being a statutory social worker, responsible for the day to day decisions of a case. I also had a particular authority invested in me as an 'expert witness' brought into cases in order to determine the best care plan for the child. This imbued me with a high level of power informing what social workers would reveal to me or not. However, I also provided

reflective supervision, coaching and mentoring and training to the social workers developing quite a good rapport with many of them and a feeling of trust and understanding.

The advantage of this ‘familiarity’ was that social workers really opened up to me on quite a deep level during some of the interviews. I did not seem to be identified with senior management as many of the social workers felt confident in opening up about their critical views towards management. **The interviews also seem to provide containment, whereby highly defensive and emotionally disconnected dialogue about practice became less defensive (See case studies in Chapter 4). As I have argued there is never an objective, neutral position free from the researcher influence or bias. The objective can only be known through the subjective. Therefore, this researcher became subject and object (Giami, 2001).**

In this study I was in the unique position of knowing the families that the social workers were talking about. I had met the parents and children and had inside, intimate knowledge of the case. We had a shared experience. Sometimes it is clear from the interviews that the social workers felt they were talking to someone who could understand them on a deep level. I had experienced the dynamics and emotional impact of the case myself. I think this elicited information that they had not fully become aware of themselves. Up to that point the social workers had not been provided with a space in supervision or team discussions to share their experiences fully. At times this involved experiencing very difficult circumstances such as the unexpected death of a parent, dealing with multiple pregnancies or taking children into care.

There are of course disadvantages of being on the inside. For example, I was emotionally invested in the outcome for the child and developed strong views from direct knowledge of the participants. This meant I needed to gain criticality about the material. An evaluative position sees the material as new and allows for that which is not known about, to emerge. This repositioning was achieved in part by acknowledging and understanding the biased nature of my knowledge of the cases. For example, in writing up the first draft of the research I discovered that Chapter 4 was written in the mode and voice of an ‘expert witness’ confident in their opinion about the case. A confidence that is required by the judge when presenting evidence to court. I am commissioned to offer certainty and confidence in order to help the court reach a decision on the best interests of the child. However, as a researcher I have to be open to new ideas about the material and be less strident. Equivocation and alternative meanings can be offered rather than certainty.

Research Design

This section describes the research process and its design, and how it relates to the research questions. The research consists of two different phases (Part One and Part Two) and two different data sets. The findings from Part One can be found in Chapter 3. Part One pursues the themes emerging out of the background and demographic information collected while working with the families. I have called this retrospective data. This consists of case notes taken during, or shortly after home visits and information taken from the parenting assessments and court documents. The analysis of the case notes and parenting assessments produced themes that were then categorised across cases in order to discover and compare similarities in patterns across families (Bryman, 2012).

This process triggered a natural curiosity about what had happened to the children after my involvement. Therefore, Part Two was devised and I decided to interview the social workers using a semi-structured interview schedule, the findings of which are reported in Chapters 4 and 5. The interviews covered subjects such as: The social worker's memories of the case at the time of assessment; What had happened to the child since my involvement; Any contact the children had with their parents; And the social worker's views on the decisions that were made. These interviews provided rich, detailed accounts of the social worker's experiences of the cases, in particular the emotional impact of the work and the unconscious dynamics in their decision making. Themes arising out of an analysis of the interview material were, again, compared across cases. Themes arose which led to valuable knowledge of the psychodynamic factors involved in decision making. I have presented these themes as in-depth case studies in Chapter 4. In my view, these case studies capture the richness of the work and vividness of the inter-subjective factors and dynamics of child protection decision making.

This was a relatively small research sample so wide statistical significance cannot be determined from the data. However, the themes that come up are highly illustrative of the kinds of complex issues that affect the decision making process in children services.

Research Questions

I was concerned with a number of questions regarding decision making about the children I worked with, within this particular social work organisational setting and the parenting assessment work. The research questions were formed as general inquiries into the subjects and areas of interest and then they developed as the research progressed, cohering around one area of particular interest. The main research question

became about the exploration of the emotional and unconscious factors which affected social worker judgement.

Part One - Retrospective Analysis of Data Gathered from Parenting Assessments

Summary of the Cases

I began the research process by looking at the case notes and parenting assessments from my social work practice between 2006 and 2008. I had assessed 17 families, involving 31 children in total. In some cases I undertook more than one parenting assessment. For example I may have assessed the mother and father separately. On some occasions I assessed grandparents and in one case a great grandmother. Therefore I undertook 23 parenting assessments in total, capturing key demographic information and the common problems families experienced.

In Table 1 a tabulated summary of the cases can be found. This table includes the number of the children that the cases involved, the ages of the children at the time of assessment, the child's gender, and the pseudonyms for the participants. This also includes a brief description of the issues I had been asked to consider by the local authority, such as whether the children living at home were safe, whether children in short term foster care should be returned home or whether they should be adopted etc. I have also included the living circumstances of the children at the time of the assessment, such as whether they were living at home on a family support basis, or on a child protection plan. If they were accommodated I describe whether they were in short foster term care or kinship care.

TABLE 1: OVERVIEW OF CASES

	No of children	Age of children	Gender	Pseudonyms of child/children	Pseudonym of parents	Pseudonym of SW (if interviewed)	Issue assessment addressed	Status of children at time of assessment
Case A	1	8 mths	M	Christopher	Antonia Ken	Nadia	Decision about Rehabilitation home or adoption	Short term foster care
Case B	1	6 years old	F	Kelis	Daniella Thomas	Whilma	Rehabilitation home or long term care	Short term foster care
Case C	4	10, 9, 8 and 3	M, M, M, F	Sid, Jonny, Peter, Coca	Claudette Marcus		Child protection concerns at home	Family support case - CIN children living at home
Case D	3	6, 4 and 2	F, F, M	Jade, Sylvia and Conner	Rena Jignesh Steve		Child protection concerns and removal from mother's care to live with fathers	Child protection plan - children living at home
Case E	1	10 years old	M	Jack	Kelly unknown		Abuse clarification work	Short term foster care
Case F	1	9 mths	F	Chanel	Debbie Albert	Parmjit	Rehabilitation or adoption	Short term foster care
Case G	2	15 and 9	F, F	Annie, Arlene	Julie unknown		Child protection concerns at home	Child protection plan - children living at home
Case H	1	6 years old	F	Penny	Rita Ken Carol (PGM)	Cheryl	Special Guardianship Order	Kinship care/ foster care

	No of children	Age of children	Gender	Pseudonyms of child/children	Pseudonym of parents	Pseudonym of SW (if interviewed)	Issue assessment addressed	Status of children at time of assessment
Case I	1	2 years old	F		Sarah Manjit (SF)	Mina	Rehabilitation home or adoption	Short term foster care
Case J	1	5 mnths old	F	Lola	Sonia (SF)	Mina	Rehabilitation home or adoption	Short term foster care
Case K	1	5 years old	M	Lee	Maude	Cheryl	Rehabilitation home or adoption	Short term foster care
Case L	3	13, 11 and 9	F, M, M	Shriya, Sai and Jai	Mrs D Mr D		Child protection concerns at home	Child protection plan
Case M	1	6 years old	F	Paula	Mother - Susan Father - Gary	Wendy	Rehabilitation home or long term care	Short term foster care
Case N	3	7, 6, 1	F, F, F	Kelly, Pamela, Christine	Mother - Samantha		Rehabilitation home or kinship care/SGO	Kinship care/ Short term foster care
Case O	1	unborn			Mother - Benedicta Father - Matt		Pre-birth assessment	Child not yet born
Case P	5	12, 10, 8, 7, 3	M, M, F, M, F	Benjamin, Kent, Wilma, Dreyfus and Mia	Mother - Brenda Father - Wally Father - Greg	Osiris	Rehabilitation home or adoption/long term care	Short term foster care
Case Q	1	12	M	Graham	Mother - Grace Father - Dave	Julie (EWO)	Remaining at home or accommodation	Family support/ CIN

Key terms:

- SGO = Special Guardianship Order
- SF = Step father

- PGM = Paternal Grandmother
- EWO = Education Welfare Officer

I was able to interview the social worker about what had happened to the child in cases A, B, F, H, I, J, K, M, P, Q. These cases are highlighted in blue in the table below. There were 10 interviews which included 8 social workers (2 cases had the same social worker). The cases highlighted in green were selected for cases studies which provided additional analysis for themes described in Chapter 3. The cases highlighted in yellow show where domestic violence had been an issue between the parents in the past or in the present. The cases in red are the main case studies I have used for chapter 5. Grey indicates those general cases used for additional background information for the themes and patterns arising from Part One of the research.

Thumbnail Sketches of the Cases

(Cases A, J and K are presented in full in Chapter 4 - therefore have not been presented in summary here)

Case B

Case B involved a 6-year-old Black UK girl called 'Kelis' who was in short term foster care at the start of the assessment. She had been in short term foster care from the age of 21 months. She was subject to a full care order with a view to adoption. Kelis was the daughter of 'Daniella,' a 42-year-old Black woman of Jamaican decent. Kelis's father 'Thomas' was a 37-year-old Black man of Jamaican decent. Daniella had an older daughter aged about 19 who had a daughter aged 2, therefore Kelis was already an aunt. Thomas had two other daughters by different mothers alongside Kelis; a 16 year old daughter and 2-year-old daughter. I have referred to this case in Chapter 3 when highlighting the effect of continued domestic violence and the fear of violence on child protection social workers.

Case C

Case C involved 3 boys aged 10, 9, 8 and a girl aged 4 years old. All of the children were living at home at the time of the assessment and remained at home after the assessment was completed. Their mother was of Irish/Malaysian heritage and the boy's father was White UK origin. The youngest girl's father was Black British of Jamaican heritage. The children had been on the child protection register off and on for a number of years and there had been a recent further allegation of physical abuse. I have referred

to this case in Chapter 3 (attacking dogs) when highlighting the effect of threatened or covert violence on social worker decision making.

Case F

Case F involved a 6 month old dual heritage girl called 'Chanel' living in short term foster care at the time of the assessment. Her mother 'Debbie' was a White 28-year-old woman and her father was a Black British man of Jamaican heritage. He was in prison for drug and robbery offences at the time of the assessment, therefore I did not meet him (the social worker did their own assessment of him by visiting him in prison). I undertook an assessment of the mother who had contact with Chanel at a contact centre. Debbie had a serious problem with drugs such as heroin and crack and was very hard to meet up with outside of contact. Her attendance at contact was unreliable and I concluded that Chanel should be adopted because of her mother's continued drug misuse. I refer to this case in Chapter 5 where I argue that a connection with the child by the social worker appears to help in keeping the child in mind. This leads to a quicker decision about the child's long term care.

Case H

Case H involved a 6-year-old White UK girl called Penny. Her 33 year old mother, Rita was also of white UK heritage. She had three half-siblings. Two older siblings had been adopted and a younger sibling (of mixed parentage) lived at home with the mother at the time of the assessment. I undertook an assessment of the step-grandmother and it became clear that Penny was an integral part of the family, she felt like she belonged, and was wanted and was being well looked after by the Grandmother. The step-grandmother went on to become her foster carer followed by obtaining a Special Guardianship Order through the court process.

Case I

This was a very sad case in which the mother was murdered by her partner. The child I initially assessed was the mother's first child aged 2-year-old. This mother had two more children following this child, before she was murdered by her partner. The child was an Asian girl called 'Neeta.' Neeta was in foster care at the start of the assessment. Her mother, 'Sarah' was only 18. She had a serious addiction to alcohol and drugs and had been known to social services for years due to neglect and suspected sexual abuse. During this assessment I conducted viability assessments of Neeta's Maternal Grandmother and Maternal Great Grandmother and therefore got to know the intergenerational patterns in the family well. Following the assessment of Neeta, who was adopted, I assessed Sarah in relation to her next child. I also assessed the father of

the baby. This baby was adopted. They went on to have another baby who was removed from their care and shortly afterwards the father murdered the mother. I chose not to write about this case for the research due to the sensitive nature of the case (it was widely publicised across the country) and the complexity and distress the case still causes.

Case M

Paula was a 9-year-old girl of White UK origin. She was in foster care at the start of the assessment and moved to her paternal Aunt's at the end of the assessment under a Special Guardianship Order. Paula's mother 'Jenny' had a long term alcohol problem. She had been evicted for anti-social behaviour. She was also in an abusive relationship with her partner. Paula's father had not had any connection with Paula until the court case. He was notified of his daughter's circumstances as a result of the care proceedings and I assessed him as well. Eventually, Paula moved to her paternal Aunt's care with her 5 cousins. I use this case to highlight the emotional connection the social worker has with the child and link this to the good outcome for the child (Chapter 5).

Case P

This case involved 5 children, Benjamin, Kent, Wilma, Dreyfus and Mia (aged 12, 10, 8, 7 and 3 respectively). The two oldest boys had a different father to the next two children. The youngest girl had a different father to the rest of the children again. Benjamin had been accommodated and was placed individually in a short term foster care placement which was to become permanent. Kent was in a short term residential unit when I visited him, doing quite well. The youngest there were placed together with an African family who wanted to adopt the children. The mother in this case was 'Brenda,' a 40 year-old-white woman. She had a long history of alcohol abuse. The father of the oldest two children was a younger black Caribbean man called 'Wally.' He was 35 at the time of the assessment and was married to an Asian woman of Pakistani heritage. The next two younger children had a father called 'Greg.' All of the domestic violence incidents reported below were in relation to him. He had a crack cocaine and alcohol addiction and a criminal record for violent offences including ABH relating to the children's mother. I use this case to highlight the effect of domestic violence on children in Chapter 3. I also use the case to highlight the effect my own countertransference responses towards the children effected my decision making (Chapter 3).

Case Q

This case involved a 12-year-old boy who was living at home at the time of the assessment. Although subject to a full care order he had recently been returned home by a judge in care proceedings as his foster care placement had come to an unexpected end. He had expressed the wish to return home. His mother and father were living separately but were in a relationship. The mother decided to end her relationship with the father after the assessment.

Part Two - What Happened to the Children Since My Involvement

Interviews with the Social Workers

The second part of the research involved interviewing the social workers to find out what happened to the children after my involvement. I interviewed 8 social workers, regarding 10 families (2 cases had the same social worker). Therefore, I explored 10 cases in depth through a qualitative analysis of the interview material. Interview data relates to 14 children in total. Interviews were voice recorded and then transcribed. They usually lasted up to one to one and a half hours.

Semi-structured interview schedules were used during the interviews to explore the emotional factors involved in decision making. I asked the social worker about their memories of what happened at the time of the parenting assessment, the thoughts and feelings they had about the decisions that were made, and to provide me with an update to include; the child's relationship and contact with their mother or father; whether they supervised the contact or not; an appraisal of the child's development; the social worker's estimation of how well the placement was going and how it may be in the future. I asked whether there were risks associated with the placement breaking down.

These questions were constructed in such a way as to open up a discussion about the child and the decisions made about them. It left enough room for the social worker to tell their story about the case and outcomes. However, it also ensured a similarity of questions across cases. The social workers opened up to me in a lot of depth and provided nuanced accounts of their thoughts and feelings. Sensitive questioning during the interview added to their feeling of being listened to and created a safe space for them to reveal the usually more hidden thoughts and feelings about the case, in particular their more difficult feelings. Therefore the interview schedule provided some structure and a framework across cases but was flexible enough to open up the

discussion into a free associative style similar to the one Hollway and Jefferson propose (2000). If the social worker wanted to talk about something urgent I followed their lead, prompting them to open up about the ideas that they were bringing. My social work interviewing skills allowed for the less spoken about experiences of the cases to be explored in depth.

I was able to mitigate the power dynamic inherent in my role as 'expert witness' by using my skills to get alongside the social worker, eliciting information and their views in a sympathetic, non threatening way. Prior knowledge of the child and the work, including the dilemmas the social worker faced made it easier for the worker to open up and trust that I would understand what they were saying. However, it was clear from some of the interviews (Cases J, M, P) that the social worker did hold a certain level of ambivalence towards me. My position of power as an expert witness and differences of opinion we may have had made ambivalence inevitable in some cases. In this regard it would be difficult to argue that the accounts the social workers provide are of the full view of the parenting assessments. They probably presented partial accounts of their views.

I also made sure that the social workers received information about how the research would be used in plenty of time before we met. They knew that information would be treated confidentially, it would be anonymised and was for my own purposes for research and self development. I explained that any themes arising out of the interview would be fed back to the organisation in a general way only in order for confidentiality to be maintained. However, it was explained that themes would lead to improvements in the service and therefore their views were very important to make a difference to the way the organisation supported their work. All but one social worker agreed to be voice recorded. The social worker who did not want to be voice recorded allowed me to take notes during the interview (Case B).

Thematic Analysis

The case notes, parenting assessments and interview material were analysed in a systematic way, using thematic analysis to identify patterns within and across cases (Braun and Clark 2006). For example, I read the text of the document under consideration, identified themes which I then analysed and grouped together. I then looked for whether the theme reoccurred again in the text of the document under consideration, the prevalence of the theme, and how key the themes seemed to be in relation to the research questions.

After I had analysed one case I looked to see whether the same theme emerged in the next case. I repeated this process when I identified different themes, until I felt I had

exhausted the data for themes. Once I had identified themes I re-examined all the data collected under each theme to try to interpret the underlying meaning of the theme, and a pattern of relationship between the theme and the research question. I concentrated on themes which I thought highlighted some pattern of relating between various people (such as between the mother and child, the mother and social worker, the social worker and child, the social worker and I), or which captured the sense of some inter-personal dynamic. In particular I looked for themes which related to the decision making process and the way the emotional impact of the work on the worker may have affected their judgement. An example of data analysis is captured in Table 2 on page 60 below.

It has been argued that thematic analysis is a ‘rarely acknowledged, yet widely used’ qualitative research method (Braun and Clark, 2006). Braun and Clarke clarify what is meant by thematic analysis in order to outline the parameters of what it is and to justify its application for use in psychology. They describe it as an highly flexible qualitative method which can sit within other research methods such as grounded theory. It can also sit within a particular epistemological position or not. Richness of meaning is retained with its use and the primacy of experience is promoted, leading them to a deeper understanding of everyday lives. In terms of what counts as a ‘theme’ Braun and Clarke say,

‘A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set (p.82)’

There are different ways of describing data, depending on the information being relied upon. ‘Data corpus,’ refers to the entire data collected for the research i.e. in this study it consists of case notes, parenting assessments, predictions and interviews. A ‘data set’ is the specific type of documents you are referring to i.e. the interview transcript material or the case notes. A ‘data extract’ refers to an extract, i.e. a coded section of text within the data set.

It is sometime usual to find an account of themes “emerging” out of the data or being “discovered.” This is a *passive* account of the process of data analysis, which denies the *active* role the researcher always plays in identifying patterns or themes, selecting which themes are of interest, and reporting them to the readers (Taylor & Ussher, 2001). In this particular study I identified themes with a theoretical framework in mind, based on psychoanalytic concepts developed by Freud, Klein, Bion, Steiner and Britton. I have a particular interest in these concepts which describe emotional, interpersonal and unconscious experience such as transference, countertransference, projection, projective identification and containment.

TABLE 2: THEMES

Extract from transcript elucidating theme	Theme	Sub theme	Description of emotional tone	Analysis
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<p>Yeah, obviously the decision that was made at court was that the child should be placed for adoption and the local authority got a care order and a placement order (J). so I think that therefore it was inevitable that we needed to get this care order and placement order mm, you know mum hadn't, I think initially when we went for the initial interim care order we were looking for a mother and baby unit and that didn't, that didn't work out erm, so there was a lot of evidence to suggest that this needed to be the right outcome</p>	<p>The decision making process, social worker changed her mind following parenting assessment</p>	<p>Assessment helped social worker change their mind after reading the report</p>	<p>SW sounds very matter of fact and certain, as if never really doubted it or had held any other view.</p>	<p>Parenting assessment provided triangulation for the social worker in making a decision about the child.</p>
<p>Well, it felt satisfying because obviously the concern was that if A had stayed at home, she may have been, she may have died because the risk to her was very huge or she could have been injured or she was clearly at risk and that was something the local authority didn't want</p> <p>so I think you know the evidence was quite conclusive (<i>repeated many times</i>) -'</p>	<p>Views and feelings about decision now</p>	<p>Social worker moves from identification with parent towards identifying child's needs</p>	<p>Again matter of fact, and confident</p>	<p>Social worker has taken on my concerns about the safety of the child if she were to return home - she sounds factual although perhaps even amplifying concerns</p>

The systematic analysis of data (thematic analysis) was then used to reconstruct cases in the form of case studies, described in chapter 4.

DIAGRAM 1 FLOW CHART FOR RESEARCH DESIGN (PART ONE)



Case Summary and Thematic Analysis

A range of demographic information was gathered about the families in the course of my parenting assessment work, which was then presented in the parenting assessments. This information was usually obtained from social services documents, talking to the social workers, which I then checked with the parents. There was a systematic gathering of information about the family in each case, obtained through the use of Genograms, which were undertaken in direct work with the mothers or fathers. I used the information from the parenting assessments alongside information contained in the case notes to highlight themes and patterns across cases. I read the case material, summarised and categorised the cases based on the themes that I identified from my reading and interpretation of the data. The findings are presented in Chapters 3 and 5.

Triangulation and Reliability

Stake (1994 p.241) describes triangulation as generally a ‘process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation.’ But, acknowledging that no observations or interpretations are perfectly repeatable, he argues that triangulation also serves to clarify meaning by identifying different ways the phenomenon is being seen. Therefore, to a certain extent truth is relative and different perceptions of the same phenomenon can all be true for the perceiver. Experiences can be thought about from different perspectives, in different ways, and from different paradigmatically informed frameworks. For example, psychoanalysis is only one way of looking at human experience. Sociology can be used to inform a different perspective, emphasising the structural forces at play rather than individual psychological processes.

I enhanced reliability by the use of a weekly research seminar, providing an intersubjective form of triangulation where different perspectives on what was being presented from the research were explored. This was sometimes an uncomfortable process where my own assumptions, values and beliefs were examined. To reflect on your own values is difficult but necessary if a researcher, reflexive position is to be achieved. As a practitioner I had to prove the veracity of my assessments in court.

However, in research I had to prove the veracity of what I was perceiving. This was particularly difficult when reflecting on relationships and meanings, as I could not go back to the client and ask them what they meant when they said ex. Similarly Urwin and Hollway (2007) describe how, in their research into identities and becoming a mother, they used weekly reflective research groups, which helped identify blind spots in subjectivity. I also promoted reliability by having access to multiple sources of information about the families. This included case notes, contact notes, court reports, child protection reports, criminal checks, housing reports, medical and psychological reports. My assessments made up just a fragment of the information gathered about a family. This research drew on my own practice of undertaking parenting assessments. I used an infant observation approach to many of my home visits, therefore Urwin and Hollway's (2007) infant observation method was integral to generating the data for the parenting assessments which I have used to underpin the findings in Chapter 3.

The interviews with the social workers acted as a way of testing my observations about the cases and the decisions that were made. The interviews left enough space for the social worker's story and subjective experience to emerge. This proved extremely interesting as I gained a fresh perspective of the case from the social worker's point of view. I also usually also had the advantage of having access to senior managers judgement about the social worker's effectiveness on a case and a different organisational perspective yet again.

Generalisability or Comparability

When a small number of case studies are involved issues can be raised about the generalisability of the knowledge produced. For example, is it possible that an in depth examination of a small number of cases is applicable to a wider population and does the pursuit of deep experience come at the cost of generalisability? However, Stake (1994 pg 243) argues that even the single case study can have intrinsic value and include generalisability in as much as a case can encapsulate complex meanings and describe a case in sufficient descriptive narrative that readers can vicariously experience these happenings. He further argues that although the single case is a poor representation of a population of cases and provides poor grounds for advancing grand generalisation, a single case as a negative example can establish limits to grand generalisation.

Lincoln and Guba (1985) state that generalisability is not as relevant to qualitative in depth studies. What is more relevant is whether a case is illustrative and comparable. They outline four concepts central to advancing rigour; 'credibility, transferability, dependability and confirmability.' We can confer credibility if we have confidence in the 'truth' of the findings. We can confer transferability if the findings are applicable to

other contexts and confirmability if the findings reflect the respondents interests rather than the general bias, motivation or interest of the researcher. Dependability regards the extent to which we can rely upon a set of findings.

The case studies I describe are rich in detail and can be compared by practitioners with their own experiences. If the case studies are perceived as true to real life then they will hold validity and be highly relevant for the development of knowledge that is based on real time practice. This could be argued as being even more valid than the so called neutrality and objectivity of the distant researcher.

Therefore in conclusion it is my assertion that qualitative research can make theoretical and inferential generalisations and practitioner research that is descriptive and consistent with other practitioner's experiences is valid.

Ethics

I had no idea at the start of this work that I would be proposing to research the data I had collected during the parenting assessments. Therefore, I was unable to anticipate that consent to use the data gathered during the parenting assessments would be necessary from the participant. In lots of ways this makes the information I have gathered real time data, uninfluenced by the research process. It reflects how my practice has been and documents the intervention between me and the client as it is without any outside influence or consideration, other than that which surrounds the actual purpose of the work, which may be for the use of the family, social services, or the courts.

The current governance guidelines on ethics are clear that informed consent must be obtained from any participant prior to the research being carried out and this has become the established norm over the past few years when conducting any research. The underlying assumption is that the participant is someone vulnerable and at risk of great exploitation and potential harm (Stake 1994 pg 244).

This left me with a difficult ethical dilemma that I found hard to resolve completely. Was it ethical to use information that had been shared with me in confidentiality and for a different purpose. What if the client read my thesis and recognised themselves or their children in the research? Even if this was highlight unlikely, if it did occur it could cause emotional distress, humiliation or psychological harm. It took a year of discussion in supervision and research seminars to come to some conclusion. On the one hand data gathered during the assessment could lead me to a greater understanding of the common problems families face in much more depth, which in turn could lead to better provision

made for these families to prevent family breakdown in the future. On the other, if a parent or child picked up the research and read about their details emotional and psychological harm would occur. I thought I may be able to go back to the families to discuss consent but when I approached the local authority I was informed that many of the families were no longer contactable and individual social workers did not feel it was a good idea to approach children to take part in the research as they were very sensitive stages of their care plans.

It would have been extremely difficult to gain retrospective agreement from the people I was involved with during the work and my position as someone who has a role which involves an authority and power differential made this even more problematic. In many of the cases I made deeply unwelcome recommendations about a child, which may have been in direct conflict with the parents' wishes to have their child returned to their care. In a number of cases I made recommendations for the child to be removed from their family. It was highly unlikely I was going to be able to gain consent in any case within the more conflicted cases. Judith Freedman raises this as a difficulty in assessing the work of the assessor within care proceedings in general (2007).

In the end I found out that the university would provide ethical approval on data gathered retrospectively as long as the data was anonymised and identifiable features were removed. Therefore, I have anonymised the research thoroughly. Before publishing any part of the thesis or write any post doctoral work I will anonymise the work even further by amalgamating a number of the cases, changing the gender and ethnicity of participants and obscuring identifiable information. This means that no one case study would be referred to and identification will be obscured.

I sought consent from the Local Authority to use the retrospective information I had gathered during the parenting assessments. I was allowed to analyse the information I had already collected as long as it was anonymised and confidentiality was maintain. I obtained consent from the social workers prior to interviewing them, providing information about the research and what it would be used for. A copy of the consent forms can be found in Appendix III and signed copies are available on request. The research gained ethics consent from the University of East London's ethics committee and a copy of the letter again can be found in the Appendix V.

It was important in this research to be aware of the potential for the emotional harm caused to the social workers by the interviews and I legislated for this with a sensitive, cautious approach. I used my skills as a social worker developed over many years in order to mitigate distress. Although social workers are rarely seen as vulnerable to emotional harm the interviews revealed that they did find the work they were involved

in distressing and sometimes even traumatic. At times they were visibly moved by what they were saying. Many expressed vivid memories, strong emotions of anger or sadness at the deaths of their service users. I was as sensitive as I could be to the emotional content of what people told me and made sure that the social worker's emotional well being was attended to in the interview. Indeed the interviews were containing and were valuable for the social workers. Social workers felt really understood and I still receive a warm response from one of the social workers every time I see her (Case J).

I did not feel that any of the social workers needed immediate mental health assistance or therapy but I was sensitive to their need to debrief. This is one of the main findings of the research; that social workers needed an opportunity to debrief about these traumatic cases, and what happened in one case could affect how the social worker approached another case, directly affecting decisions.

Authorisation

I had the full agreement of the local authority to conduct the research (Appendix IV). Senior management including the director and head of service took considerable interest in the research and facilitated it to a high degree. There was good preparation time for the social workers to gain an understanding of the aims, as my request had been raised with staff by management through the email system prior to commencement. However, it was always made clear that it was their choice whether to take part or not.

Conclusion

The choice of methodology relates to the research questions themselves. Methodologies and research design need to allow the knowledge that we are interested in to become available in order to be researched. This research design is concerned with the quality of relationships and the *feel* or *experience* of particular cases and assessments. The psychoanalytically informed theoretical framework used is the only appropriate analytic framework for the key psychodynamic concepts such as projection, projective identification, transference and counter-transference. It was necessary to design a qualitative research methodology that allowed for the richness in the data to emerge, which could then be interpreted through a psychoanalytic framework (Froggett and Briggs, 2012).

3. Findings from Part One, Themes and Patterns Across Cases

The decision to explore the themes and patterns across the cases, arose from a keen curiosity about the factors affecting parenting in the families. It is important to articulate the kind of problems faced by families in complex cases. While undertaking the parenting assessments I had a sense of the factors common to the cases but I had no opportunity to stop and reflect on the problems in any depth or to think about the differences between the families. This reflects the wider situation for social work with children, where it is difficult to establish an effective thinking space or to undertake reflective practice.

When I began categorising cases around specific themes for the research it was not clear what I would find. Therefore, it was a surprising that such strong themes surfaced with something new and striking coming out of examining the data. It was evident that it was not just a process confirming my biases and ideas, but a journey of discovery. I examined the demographic information in the cases, such as gender, age of child, ethnicity, employment etc. Very strong themes emerged about the high percentage of relationship breakdown between the parents, fathers, the chronic nature of concerns, cases being in the system over many years while children were at risk of significant harm, and most strikingly, intergenerational abuse. This shows the tragedy behind the family's difficulties with many of the parents describing abuse in their own childhoods. Themes and patterns are listed below in table 3.

TABLE 3: THEMES FROM CASE NOTES AND PARENTING ASSESSMENTS

Themes from case notes and parenting assessments	Main themes	Sub themes
Theme 1	Relationship breakdown	Irretrievable breakdown, on-off relationships
Theme 2	Fathers	Involved in assessments, not involved in assessment
Theme 3	Domestic violence	Occurring in the past, occurring in the present, affecting decision making
Theme 4	Addictions	Drugs, alcohol, both
Theme 5	Mental illness	Personality disorder, psychosis, depression, obsessiveness

Themes from case notes and parenting assessments	Main themes	Sub themes
Theme 6	Toxic Trio	Domestic violence aggravated by addiction and/or mental illness creates toxic environment
Theme 7	Nature of social services concerns	Neglect, emotional abuse, physical abuse, sexual abuse
Theme 8	Duration of social services involvement	Stuck cases (drift and delay), relatively straight forward cases
Theme 9	Social services action/inaction	Open/close dynamic, chronic involvement, turning a blind eye
Theme 10	Intergenerational abuse	Parents were physically abused, neglected, emotionally abused, or witnessed DV
Theme 11	Turning a blind eye/ Aggression towards the worker	Overt and Covert, link with domestic violence, impact on decision making

I was surprised to find that in almost all of the families had experienced irretrievable breakdown in the parental couple relationship. These were very much parents at war, and the children the unwitting victims of failed relationships. This made me consider Woodhouse and Pengelly's (1991) original assertion that child abuse is the *symptom* of parental discord and where possible the marital difficulties should be addressed as early as possible in order to prevent discord deteriorating into separation.

Another important category was inter-generational abuse, occurring in almost nine out of ten cases. This will be taken up as a theme and covered in greater depth in Chapters 3, 4 and 5.

TABLE 4: CATEGORIES ARISING FROM THEMES

Themes	Cases
Stuck Cases	B, C, D, E, H, I, K, L, M, N, P, Q
Irretrievable relationship breakdown/ natural birth parents	B, C, D, E, F, G, H, I, J, K, N, P
Inter-Generational Abuse	A, B, C, D, E, F, G, H, I, J, K, L, N, O, Q
Children at Risk Whilst Living at Home	C, D, L, Q
Drift for children in temporary care	B, H, K and P
Drift for children both at home and in care	K and P

Themes	Cases
Domestic Violence	B, C, D, E, G, I, J, K, L, M, O, P, Q
Addictions	B, D, F, H, I, J, K, M, N, P
Mental Illness	A, B, G, H, J, L
Aggression affects worker	B, C, D, E, G, I, J, M, P

Another major theme arising out of an analysis of the cases was the fact that many of the families and children had been known to social services over many years. I collated and compared the number of years the cases had been open and was quite astonished that most of the families I assessed had been in the system for long periods of time. For example, drift and delay (cases open for more than 3 years) occurred in cases; B, C, D, E, H, I, K, L, M, N, P, Q (12 of the 17 cases).

TABLE 5: NUMBER OF YEARS KNOWN TO SOCIAL SERVICES

	Children being assessed	Previous children by parents	Parent known to social services
0 - 2 years	A, G, J, O, F		
3 - 5 years	D, E, I, K, L	A	
6 - 9 years	B, C, H, M, N, Q		
10 - 13 years	P	H	
13 + years			I, J

As can be seen: 5 cases were known to social services for 0 - 2 years; 5 cases for 3 - 5 years; 6 cases for 6 -9 years; and 1 case for 10 - 13 years. However, the parents or previous children by the parent may have also been known to social services for much longer. In two instances the parents had been known to social services as infants (Cases I and J). I describe the implications about the inter-generational nature of abuse in following sections, but this finding highlights chronic and tragic nature of concerns in some cases.

Twelve cases had what I call a 'stuck' quality (Table 3 and 4), for which there was no immediate explanation except the complexity and enduring nature of the concerns, with an apparent inability of social workers to reach some kind of satisfactory conclusion through their interventions. All of the cases lacked chronologies. Short term crisis

intervention seemed to take precedent over a longer-term view. These cases were eventually identified by senior managers as needing my assistance through an in depth parenting assessment in order to progress the care plan to some sort of resolution.

The analysis of cases uncovered different kinds of problems influencing drift and delay. For example, Cases C and D, the child was left at home in highly abusive situations for many years and I will describe these in more detail below. Cases K and P, are cases where chronic delay for the child occurred while they were in short-term foster care and on top of this they had been left in abusive situations for many years prior to being accommodated. The cases that best illustrate chronic delay for children once they were in care were Cases B, H, K and P. In these cases children were left in situations where no final decision about their future (what is now termed ‘permanency’ by Local Authority’s) was made for a number of years.

There were differences between cases which drifted and cases where the care plan progressed relatively quickly for the child. Case M is a very good example of the care plan progressing to permanency when a new senior social worker took over the case. Prior to the social worker’s appointment in Case M the child had been left in an abusive situation for years and once accommodated was drifting in short term care. The difference in the quality of the social worker’s emotional connection to the child was a key factor in progressing the care plan. In Chapter 4 I explore the ‘stuck’ dynamic in more detail through the interview material.

I have selected a number of cases that describe the themes and categories from the retrospective analysis of the cases, because there are some that better illustrate the problems in the families. These cases also capture the richness and complexity of dynamic processes, such as turning a blind eye, inter-generation abuse, domestic violence and aggression.

‘Stuck Cases’ - Dynamic Causes of Drift and Delay

In the following sections I examine the possible dynamic causes affecting social worker’s ability to progress cases to a satisfactory resolution. A satisfactory resolution would be either making the child safe in a significantly harmful situation or, if the child is in care, progressing the care plan to permanency. The dynamics leading to this ‘stuck’ quality are made explicit through clustering cases to show the underlying, unconscious processes at play, such as projection and projective identification, particularly in relation to the effect of aggression on the social worker. In Chapter 4 the dynamics leading to this stuck quality will be explored in more detail using the data from the interviews. In Chapter 4 three cases will be presented and analysed in order to capture the dynamics in

much richness in order to understand why cases become stuck, in particular the way deprivation in the parent or child (or both) overwhelms the social worker through projective processes and effects their ability to make clear decisions.

From a closer examination of the headline themes I found categories and sub-categories which indicate the dynamic causes of stuck cases (tabulated in Table 6). When looking at the category, 'children at risk while living at home' I found 4 main sub-categories:

- The impact of aggression on decision making
- Violence split off and projected into others (or animals)
- Covert threats resulting in turning a blind eye
- False compliance or avoidance that puts social workers off.

In the category - Family structures and relationship factors, I found the sub-categories:

- Aggression and domestic violence
- The effect of domestic violence on children
- Domestic violence current at time of assessment
- The ultimate consequence of domestic violence, including murder.

In the category - Abuse and trauma in the parent's background, I found the following sub-categories:

- Parents witnessed domestic violence as children and this reoccurs in present
- Abuse and trauma in parent's background results in emotional deprivation
- Parents re-enactment of abuse with their own children
- Social worker responding to parent's infantile projections at expense of the child.

TABLE 6: SUB-CATEGORIES

Stuck cases - dynamic causes	Sub category 1	Sub category 2	Sub category 3	Sub category 4
Children at risk whilst living at home	The impact of aggression on decision making - social workers leave well alone	Violence split off and projected into animals and aggressive male partners by mothers	Covert threats results in turning a blind eye/ organisational mindlessness	False compliance or avoidance puts social workers off
Family structures and relationship factors	Aggression and domestic violence	Effect of domestic violence on children	Domestic violence current at time of assessment	Consequence of DV - Murder

Stuck cases - dynamic causes	Sub category 1	Sub category 2	Sub category 3	Sub category 4
Abuse and trauma in the parent's background	Parents witnessed domestic violence as children and this reoccurs in present	Results in emotional deprivation	Parents re-enact abuse with their own children	(from interviews) Social worker responds to parent's infantile projections at expense of the child)

Children at Risk Whilst Living at Home

In this cluster I examine two cases which best capture the problem of children being left at risk of harm while living at home (C, D, from cluster C, D, L and Q). I tentatively argue that this cluster of cases represents a dynamic process that Rustin (2005) and Cooper (2005) called 'turning a blind eye,' or organisational mindlessness (Rustin, 2005). Understanding the effect that aggression and hostility, ('Overt or covert,' Bower, 2005) can have on the individual social worker and their ability to protect the child is of huge importance in understanding child protection decision making. Turning a blind eye is a potentially dangerous, if understandable, dynamic arising from the pressure on the social worker, due to being frightened, intimidated or manipulated.

My reflections on my own countertransference responses in cases where aggression and hostility had an impact on me have a bearing on this dynamic. I have a clear recollection of the emotional dynamics of cases from my perspective, and a record of the thoughts and reactions I had at the time in my case notes. These cases were emotionally demanding and capture the quality of experience of aggression and hostility that is often directed at social workers. Perhaps the emotional impact of these dynamics and the fact that the social workers had subsequently left their role, are linked. In discussions with the social worker in Case L, she described becoming so frustrated with her managers for failing to take action to protect the children that she chose to leave the local authority to work in another organisation. A conversation with a social worker in Case C highlighted her reluctance to become involved with the family due to living nearby.

Cases C, D, L and Q encapsulate those families where it was my suspicion that the organisation had turned a blind eye to abuse, unable to see or acknowledge the significance of the harm being caused to the children by their parents. The children in these families were left in their parent's care for years despite concerns about physical abuse (Cases C and L), sexual abuse/neglect (Case D) and potential neglect/emotional

abuse (Case Q). From reading the chronology it appeared that support had been offered to the families and this had been exhausted with little or no change. I will describe Cases C and D in more depth, as in my view they were the more severe cases of abuse.

Attack Dog

Case C

Case C involved 3 boys aged 10, 9, 8 and a girl aged 4 years old. The three oldest boys, 'Sid, Johnny, Peter' had a different father to the youngest girl 'Coco.' All of the children were living at home at the time of the assessment and remained at home after the assessment was completed. Their mother was of Irish/Malaysian heritage and the boy's father was White UK origin. The youngest girl's father was Black British of Jamaican heritage. Mum, who was called 'Claudette' was aged 27, of mixed English and Malaysian decent. She was young, pretty and articulate.

The youngest girl had a Black father of Jamaican heritage. There had been many allegations of physical abuse by him towards the older boys. He had moved out of the family home following a recent child protection investigation into allegations of physical abuse by the older children shortly before I undertook my assessment. In this way the family had avoided being referred for a child protection case conference for the most recent allegation of abuse (They had been on and off the child protection register for physical abuse for many years).

The father of the oldest children had no contact with the boys, having been imprisoned for a long period of time for kidnapping and assaulting their mother, holding a knife to her throat in front of the children. They were very young children at the time and evidence from the file suggested they had been significantly traumatised by these events. These 3 oldest children had been known to social services for 7 years for physical abuse by Claudette's two partners. i.e., their birth father and then their step-father (Coco's father). There was also a brief period of time early on in the case where concerns were raised about the C's physical abuse of her sons. There seemed to be a pattern that when concerns were lowered and intervention scaled down, there would be a further referral about physical abuse. This case had multiple social workers. CAMHS had made a referral just before my assessment about concerns relating to the mother's parenting. Up until then concerns had been located in the children's behaviour (ADHD) rather than any trauma or abuse they had suffered.

During observations of the children I talked to them about their experiences. The boys in particular told me quickly and in hushed tones that they had been physically punished

by their step-father, by being made to stand against a wall for long periods, being hit by him and being forced to eat hot chilli food. Sid and Johnny looked at each other quickly, describing how they had sneaked the hot food out into the yard and managed to throw it over the fence. I also observed how the children refused to go out into the back garden as the yard in front was where the Rottweiler was kept. It was obvious that they feared the dog and the mother, reluctant for me to see this, held onto the dog while they went to the back garden to play on the trampoline. She then let the dog go and it wandered into the house. Coco was frightened and lifted her arms up to be picked up. I closed the baby gate across the kitchen quickly so the dog could not come in.

Countertransference

I had an awful feeling of not being believed, about the level of risk to the children in Case C and that I was making too much of the harm they had suffered and were continuing to suffer. This must be a common feeling for children in child protection cases as abuse often goes unreported due to a fear of not being believed. Therefore, it is possible that I was projectively identified with the children, who after all, had reported numerous incidents of abuse by this stepfather over many years. Although action was taken and an investigation completed there were many entries in the Section 47 documents which simply said that the allegations were ‘unsubstantiated.’ From the children’s perspective they must have felt that they were not believed.

My worries about the children contrasted sharply with the sympathy I felt towards the mother. In particular she came across as anxious about the parenting assessment, in case it focussed on her rather than what she deemed the children’s difficulties. We made a good connection in the first visit where I explained the purpose and focus of the parenting assessment and why it was needed. I tried to get a alongside her so that we could think together about her parenting. In the first visit I also gained a history from her covering her own childhood experiences. It was clear that she had had a difficult childhood. She referred to her father being very dominating and her mother being depressed. She began sexual relationships with much older men at the age of 14 years old. She claimed that her parents allowed her to live with her older boyfriend at that age as they could do nothing about it. This partner began to be violent towards her when she became pregnant, torturing her puppy in front of her and punching her in the stomach. She had eventually been held hostage by this partner in front of her children, with a knife held to her throat. She had bought the ‘attack dog’ in response, never to experience being placed in such a vulnerable situation again.

Claudette cried at our first meeting and was very upset that her parenting was being assessed rather than the children’s behaviour. However, she also said she would engage in the assessment process with an open mind and I thought that I would be able to form

a good working relationship with her in order for her to look at the concerns seriously and to change the situation for the children. I believed she wanted help and just needed the right kind of support.

This hopeful feeling was shattered early on in the assessment after I raised concerns based on observations of the children being frightened of an 'attack dog,' alongside two other mastiffs living in the home. I raised this concern with the mother after seeing how frightened and excited the children were around these dogs. They would refuse to go through to the back garden without their mother's presence as the Rottweiler barked at them. They were frightened by the dog. I had a strong reaction of fear and shock regarding the potential dangerousness of the three dogs in the home, which I thought represented the projection of the mother's aggression into her pets. I raised this observation of the children's fear of the dog gently with Claudette. Unexpectedly during the next home visit (an evening visit), the children's stepfather 'Marcus' was there. Marcus became quite heated in his views and opinions about social services involvement saying that they should keep out of his business. He said there was nothing he should change about his parenting and that social services were interfering. He was a very muscular man, who obviously took a lot of care building up his bulky physique. He was very keen to show me that the dogs were harmless and got the boys to chase the French mastiff around the dining room, which I found rather surreal. The children were hugely excited by this staged event.

From observing their complicity over the dogs, I wondered if the parents had really separated. There was an air of compliance in the mother, which when her view of the family was challenged elicited a more aggressive and threatening response. When threatened, the dogs came out! Her fear of me was communicated effectively, through the introduction of the father and the dogs. I wondered whether the mother projected her aggression into her partners, along with her dogs. When I looked at the chronology honestly it showed that Claudette continued to have a relationship with the step-father for many years following allegations of quite cruel and brutal physical abuse towards her three eldest sons. Serious bruises had been found on the children following allegations of physical abuse by the step-father. The physical abuse was accompanied by cruel and degrading punishments, which the children told me about during the assessment such as standing facing the wall with trousers down, eating very hot chilli peppers. This abuse resulted in them running away.

I remember being frightened on a number of occasions during this assessment. Claudette had a Rottweiler, which she had bought after the incident with her ex-partner, in order to 'protect' herself. She called it an 'attack dog' and it was kept locked behind a fence in the yard. During one visit it was let into the home 'inadvertently' while I was there. Coco, the 3 year-old-girl was also very frightened and quickly put her arms up for

me to pick her up. We hid together behind the baby gate in the kitchen as the dog sniffed around us. I thought the baby gate was a rather flimsy and inadequate barrier between us and the huge dog. The older boys also expressed their fear of the dog and wouldn't go near it. Therefore, I strongly felt the fear that the children experienced. During my last visit I heard the 'attack dog' barking from all the way down the street. I was going to the final home visit in order to tell the mother about the recommendations of my report. I felt my stomach lurch as I walked up the road to the house and I remember a very careful conversation with Claudette where I was conscious that she could set the dog on me at any moment.

The mother sat outside the house on the doorstep smoking, on my arrival expecting me. She sat close to a rather too flimsy wooden stick holding the gate closed as the dog continued to bark from behind. I had the feeling that if I said the wrong thing about the recommendations that she may have pulled the stick away, although I also dismissed this idea to myself as paranoid! The child protection service manager considered an initial child protection case conference following my report but decided it was not necessary as the mother was complying and had made changes by getting rid of one of the dogs (ironically or even symbolically not the attacking dog but the French mastiff).

The recommendations were uncharacteristically equivocal in this case, *suggesting* that the children should be made subject to a child protection plan rather than recommending this in a straight forward way. I also suggested other ways forward such as psychotherapy for the mother. I made further recommendations such as the attack dog being re-homed. Although some of the recommendations were acted upon in part (an initial child protection conference was held, the mother was requested to find a new home for one of the dogs although not the attack dog) the main point was that I believed the children to be at continued risk of physical abuse from the step-father. However, the local authority did not agree as they took the parent's assurances that he had moved out at face value. My hypothesis was that Marcus still lived in the family home. Or, if he did not, he still had a high level of contact with the children, as he was asked to look after them alone during the week while Claudette went out to work. Due to my observations over Marcus's and Claudette's complicity over the dogs I thought that it was possible that they could collude over other matters. This was just my suspicion. In hindsight I thought I was equivocal as I had been frightened by the experience of the parenting assessment.

Killing Kittens

In Case D the 3 children had been known to social services for 5 years prior to my involvement. The case involved 3 children, Jade, Silvia and Connor aged 6, 4 and 2. Their mother, 'Rena' was aged 30 and of white UK decent. Jade and Silvia had the same father, 'Jignesh' who was Gurjerati Indian. Connor's father, 'Steve' was white UK. The children had been on the child protection register for many years due to concerns about neglect as it was suspected that their mother had an alcohol problem. Referrals consisted of police being called when the children were left home alone, or when they responded to domestic violence calls Rena was found highly intoxicated and unable to care for the children.

Both fathers had serious histories of drug abuse and there was domestic violence reported mostly in the relationship between Rena and Steve. There had also been reports of violence between the older girl's father and Rena but to a much lesser extent. Unlike any of the other parents in the study, Jignesh successfully attended a long residential rehabilitation for his drug abuse and had tackled his addiction in a serious way. He lived with his parents.

Jade disclosed that she had been sexually abused by a neighbour a year prior to my involvement and this allegation was being investigated by the police. The man had been arrested and was on bail. Silvia, had also disclosed sexual abuse by the same man just before my assessment began and this was also being investigated. During my assessment I came to suspect sexual abuse of the youngest boy, due to some concerning drawings he made while I talked to him. He made drawings of snakes and although this would have been innocuous in normal circumstances, his emphasis on the importance of the snakes made me think they were more significant than usual. I knew that the children had been left at continuing risk of sexual abuse by the neighbour while I was there obviously expecting a friendly reception and to be let into the home. It had also been reported to the police that Rena left the children with young neighbours while she went out and these young people subsequently left the children home alone. This was verified in a recent police report. Rena was also said to continue to call for the man who had sexually abused the girls and during my assessment the offender came to the door. Rena tried to hide this from me but the children told me they were afraid of the man who their mother was talking to. She tried to hide who was at the door from me and stop the children from telling me who it was.

During my assessment I found out that Connor was locked in his room or the front room when he was naughty. The children came across as wild and out of their mother's control. For example, they ran around the front room jumping off furniture and hurting themselves. They refused to respond to their mother to calm down and didn't listen to

her. They ran out into the street placing themselves at risk. They screamed and shouted continuously, or cried and wailed and hit and scratched each other. One of the children pulled her belly button in a very disturbing way. They seemed preoccupied with scary objects when I drew pictures with them, and they whined or fought constantly between each other. They told me that they had had a kitten which was killed by their mother. They kept opening the fridge door during one visit, in order to show me the wine inside. The mother became very angry with them for revealing the problems in the home. The girl's behaviour in their mother's care was in stark contrast to their behaviour in their father's care, where they were calm, sensitive, prettily dressed and well behaved.

The social worker told me that she did not visit the children at home as it was very difficult to make plans with the mother and she only visited them at school. The social worker and manager told me that they preferred to wait for the fathers to make applications in court for Residence Orders, rather than initiate care proceedings themselves. There was a high level of delay after my report until the fathers applied for residence orders through court. Despite my concerns about Conner's father, who was drunk during my visit to him during the day, and despite the history of drug abuse and domestic violence, Conner was placed in Steve's care. When a Children's Guardian was attached to the case Conner had to be moved again, as she was unhappy with the local authority's plan.

Countertransference

I found it extremely difficult to engage the mother in this case and remember feelings of fear and trepidation when I visited the home. I would often walk up to the house wondering whether the children and mother would be in and half hoping they were not. I would feel a sense of relief when the door wasn't answered. However, I was aware of this reluctance in myself and compensated for it by being even more persistent, until my persistence paid off. Due to my perseverance I gained access to the house and was able to make a good assessment of the situation. This was in contrast to the social worker who had given up visiting the children at home due to the problems with access.

I could understand why the social worker did not want to visit the home, as visits were often very unpleasant and tense. The mother was difficult to talk to and there was tension in the communications between me and the mother. I was also left feeling very disturbed by some of my observations of the children, including being told by them very quickly during one visit that their mother had killed their kitten by throwing it against the wall. The children also told me quickly so that their mother couldn't hear, that they were frightened of a man came to the door. This was the neighbour who had sexually abused them and who, according to the notes and now the children, continued to be allowed into the house by the mother. This indicated an idea that they were still

continuing to be at risk of sexual abuse due to the mother's neglect. These visits used to fill me with anxiety and tension. It would feel like the mother was potentially explosive and could have punished the children after I left. When I left they would come to the window to watch me leave and this made me feel guilty and afraid to leave them. In this way the children communicated their fears very effectively to me.

It is highly probable that the mother was afraid of me and therefore was hostile and aggressive towards me as a way of trying to get rid of me. I didn't allow this dynamic to effect the assessment and I remained clear about my concerns for the children, particularly as I feared that they continued to be at risk of sexual abuse and felt an urgency to protect them. I thought the children should be removed immediately but frustratingly, the local authority waited until the fathers applied for Residence Orders through court. This felt like a totally inadequate response to some serious continuing concerns. The children's Guardian who was later appointed criticised the local authority for their lack of action to protect the children in a timely way. The social worker left shortly afterwards and it was my fantasy that she was asked to leave due to her lack of action to protect the children.

Organisational Dynamics

I would tentatively describe these two cases as representing the dynamic of 'organisational mindlessness' (Rustin, 2005) as the children's experiences seem to be glossed over by a highly defended organisation and practitioners who are disconnected from the children's emotional experiences and their need to be protected. It could be that the children had become objects of disgust (Ferguson 2011, p.167) with the mother's neglect becoming mirrored by the social workers or that fear made practice defensive and practitioners avoidant of visiting the children at home. I found the cases emotionally exhausting as I was fearful for the children and at times, fearful for myself. In Case C, I thought that a senior male child protection worker was overly willing to believe the mother's assurances about her partner leaving the home (For a description of Case C see section on 'Attack dogs' (page 86). I wondered about the effect her prettiness and articulation on professionals. It could be speculated that the idealisation of motherhood effect the cases. Female aggression is generally denied, leaving these women 'marginalised' (Weldon, 1988) and consequently treatment is scarce. However, there were more contributing factor that explain the inaction or drift, such as; A high turnover of staff; a lack of experience in the social work team; Overwhelmed or frightened practitioners; Higher risk cases taking priority; A culture of opening and closing cases with minimal intervention; Risk thresholds becoming too high, etc. (Though the turnover of staff also seems to be linked to the case dynamics). Once the organisation opened it's eyes to the abuse, usually through my assessments social workers were punished and disappeared.

Aggression and Turning a Blind Eye

There was a high level of aggression and hostility in many of the cases and in some, huge pressure from the parent to sway the judgement of the worker. Many of the difficulties the parents had were either hidden, minimised or denied. Some of the parents appeared to want to change and complied superficially with engagement and others just simply avoided the social worker so effectively that it was difficult to make headway. Social workers also seemed to lose sight of the child's needs and had little understanding of their emotional development. One of the main differences I found was that although I took a detailed assessment of the parent's difficulties, history and thoughts my main focus in the assessments remained on the children. By being child focused and having a training in child observation my assessments focused on the harm to the child based on an understanding of emotional development. Examining a thorough history of the case also made me aware of the duration of the concerns and patterns of repetition. This historical perspective meant that I was less swayed by the parent's pressure in the moment and was able to take a longer view. I worked for a short time with the family so I was also less likely to become embroiled in the underlying dynamics that had prevented many social workers from seeing the problems clearly (As described by Brandon et al 2007 and 2009). Perhaps the fact that I knew I would have no continuing role with the parents made me braver and more honest, less likely to be swayed by the feeling of being hostage to the emotionality of the case that Ferguson describes along similar lines to Stockholm Syndrome (2011). Despite this, I often found myself frightened to relay my conclusions to the parents. I was frightened at some point during many of the assessments or worried about the repercussions of my conclusions (Cases A, B, C, D, E, G, J, M, P, Q).

My experience as a practitioner leads me to believe that the underlying aggression and pressure from the parent made the organisation turn a blind eye to the abuse (I say this despite there not being supporting interview evidence that reflects the views of those involved). It is an area that needs a further research study that can capture the hidden nature of aggression or hostility and its affects on decision making. This would be difficult to study but one that is extremely urgent. For example, in Case C the social worker told me openly that she did not want to become involved with the family by opening the case long term as she lived in the same street as them and this made her uncomfortable about the repercussions.

The psychoanalytic term for turning a blind eye is called 'disavowal' it describes the concept of when something is known about but the significance is denied, or repudiated, at the same time (Cooper, 2005). It also relates to Steiner's (1993) concept of Psychic Retreat, which refers to the withdrawal from contact by a person, usually in borderline or psychotic functioning, whereby the person becomes heavily defended from emotional

contact with the analyst as a way of avoiding anxiety and mental pain. In this way the retreat offers an illusion of safety and is hard to break through. He links this to the death instinct and self destructiveness:

“Traumatic experiences with violence or neglect in the environment leads to the internalisation of violent, disturbed objects which at the same time serve as suitable receptacles for the projection of the individual’s own destructiveness.” (Steiner, 1993, p.4)

The concept of ‘psychic retreat’ is very important in the problem of understanding why abuse goes unnoticed or is not acted upon by social workers, even when in hindsight it may seem perfectly obvious that it was happening. The underlying schizoid dynamics in situations where the parent can split-off knowledge of their aggression and hostility towards the child are very powerful, but they are capable of hiding psychotic or sadistic thoughts behind a functioning, co-operative presentation. Awareness of these troublesome thoughts is defended against by being denied. In Case K, it was symbolic of the psychic retreat that the door in Maude’s home was closed. I failed to open it during the parenting assessment. Behind it hid her 21 year old son, possibly injecting heroin into his arm and it is frightening to think that it was only a few weeks after my assessment ended that he died of an overdose. The discussion about her partner’s deaths took place in a relaxed calm atmosphere, sun coming into through the window, with Maude brushing her long hair, and talking with gentle humour. This dissociated state was cut off from the reality of what she was describing. It provokes thoughts about the inevitability of Lee’s death if he had remained at home, internalising parental models based on deathly objects.

Another symbolic moment capturing the psychic retreat occurred in Case C. The fear in the mother about my recommendations was projected effectively into me, as I walked up the street to the home and heard the frenzied barking of the attacking dog. Claudette sat looking nervous, smoking a cigarette on the step in easy reach of a flimsy piece of wood keeping the gate closed. The piece of wood was the only defence between me and the dog and I remember being extremely careful in the wording of my recommendations. My recommendations were also watered down, her hostility and aggression having a successful effect on my assessment. For example, I really believed that the children were at continuing risk and really it would have been in their best interests to be removed. However, I recommended that the children should be placed on a child protection plan, that the mother should undertake psychotherapy and the dogs should be removed. A child protection conference was convened but professionals decided that mum was working with the local authority and the children did not require a plan. One dog was removed (not the attacking dog) and some short term counselling was found for the mother. I believe my recommendations would have been stronger if I had not been influenced by covert

threats. Bower describes this as projective identification with the aggressor as a means of appeasement.

Countertransference Responses to the Children

Many of the decisions I made were in part informed by a countertransference response I had about a realisation of the risk to the children during home visits or in contact sessions. For example, in Case J (discussed at length in Chapter 4) I was extremely taken with how tiny, soft and vulnerable the baby was when I visited her in her foster care placement at the start of the assessment. Visiting her first before visiting any of the adults helped me to keep her in focus throughout the assessment process. Laila was snuggled into her foster carer's breast. The foster carer was maternal, protective and gentle and she produced an atmosphere of calmness, safety, sensitivity and attunement towards the baby. The home environment was clean and orderly. I could not envisage such a tiny, fragile and peaceful child, snuggled up and loved, removed from the safe breast of her carer to be placed in the chaotic, frightening and violent atmosphere her birth mother and partner created when I visited them at home. This mother was a mother who was in and out of psychosis, complicated by an alcohol and drug addiction and who was in a physically and sexually abusive relationship. The contrast was too great. It was also difficult for me to understand the social worker's cut off, distant approach towards the baby, as if the baby did not exist in her mind (see Chapter 4 for a full account of the interview with the social worker who is unable to turn her mind towards Laila due to a preoccupation with the mother's needs).

In Case C I responded strongly to the fear in the children with my own equal feelings of fear when the large Rottweiler and French mastiff dogs were let into the house. The two year old girl placed her arms out to me to be picked up in obvious fear. The older boys refused to walk through their yard to the back garden for fear that the Rottweiler would attack them. All of the children expressed fear in particular about the loud, barking Rottweiler. However, the mother ignored these obvious signs of fear in the children. When I raised it as an observation with her gently she dismissed any suggestion that they were frightened. She reacted by bringing her ex-partner into the next evening home visit, where he talked angrily at me. They staged a situation where the children chased the two Mastiff dogs around the dining room to show me how safe the animals were which had a very surreal quality for a number of reasons. Firstly the fact that the mother had invited the 'ex-partner' to the home unexpectedly gave the home visit an unpredictable quality. I was surprised and a little frightened by his presence as many of the physical abuse allegations the children had made in the past. He was also very angry with 'social services' for interfering and I was on edge because there seemed to be a veiled hostility towards me, who was obviously interfering about the dogs.

It was also very difficult because of the difference between what I had observed in the children's reactions and then what the parents were asserting about the gentleness and safety of the dogs. This straight denial of vulnerability and my reality was difficult to challenge. At the end of the assessment I felt dread walking up to the house for my last visit in order to discuss the recommendations. The mother was sat on the door step smoking, next to a gate behind which the Rottweiler dog barked loudly. There was a flimsy piece of wood holding the gate shut and I felt a very strong sense of covert threat, and that if I said the wrong thing the piece of wood could have been removed. I had a taste of the threats the children must have felt at times, threats used as a way of control.

In Case P I felt an arrest of my senses, aware that something very significance was occurring in our communications. The blood drain from my cheeks and a seriousness descended as the 11 year old boy described witnessing his mother being punched in the face when he lived at home, vividly describing the punch as making a 'bloody hole' in her forehead. He also told me about his fear of his father, an incident where he was hit for climbing on roofs, but which I also thought had an allusion to sexual abuse, as he was made to lick his father's finger. This direct evidence contradicted an assessment conducted just prior to my assessment, by an experienced and well regarded child and adolescent psychiatrist. His assessments as that the allegations had an unreal quality which he did not believe. His opinion was that the child was making up allegations about his father. My countertransference responses told me that the child was distressed and ashamed, as he hid his face behind a cushion when he talked to me. I thought the atmosphere in the room was serious and tragic and I was moved to tears. Being moved is a sign that someone is telling the truth. I didn't doubt his account of these traumatic events at all.

These are just some of the examples of how I opened myself up emotionally to the communications of the children, sensitising myself in order to recognise their pain and distress. In this way I took their situations seriously and held their safety in mind. The children were able to use projection of feeling states in order to communicate their experiences into me, and by attunement I was able to respond to their pain. I was able to use countertransference as a way of exploring the children's experiences as different from their parent's descriptions which aided in assessing risk and making decisions about the children's futures.

Family Structures and Relationship Factors

Most of the 17 cases examined involved chronic relationship difficulties between the birth parents which had led to the parent's separation, on off relationships, arguments, domestic violence or an irretrievable breakdown in their relationship (See Table 4). This is a very significant finding as it highlights one common factor which crosses all of the cases. It is usually obvious to us that relationship problems play a large part in our work with troubled families but this finding suggests it is more significant than we usually give it credit. Social work does not always address couple relationships, usually treating the 'symptoms' rather than the cause. The seminal works of Mattinson and Sinclair (1979) and Woodhouse and Pengelly (1991) being the exceptions.

Social Workers are rarely trained in family therapy and relationship counselling. However, family therapy is now re-emerging as a skill which is being taught to experienced social workers - in the light of Munro's highlighting good practice in the Hackney Model (by Morning Lane Associates). This therapeutic model is being replicated in other London Boroughs. It would be useful to know of it's effectiveness and whether any research has been conducted - also of it's survival as a model of good practice in the political climate of austerity and cuts. From first hand practice knowledge they are effective and their work is hugely helpful to social workers and families particularly where concerns about relationship difficulties and domestic violence are emerging.⁴

Despite relationship difficulties and separation being a common theme in all of the cases we also know that it is relatively common for parents to separate after having children and therefore it cannot be the main factor leading to this level of social work involvement. The relationship difficulties in these families are much more severe than in the larger population resulting in domestic violence.

Aggression and Domestic Violence

In the case studies above (Cases C and D) I have highlighted the role of aggression in the wish to turn a blind eye. When faced with a level of conflict and hostility it is likely that fear will make us turn away, downplay concerns, placate parents. The cases I have described all have an element of domestic violence in the parent's past and in this section I extend the theme of aggression and it's impact on decision making.

Domestic violence occurred in a high proportion of cases. 13 of the cases involved significant domestic violence occurring either in the past or continuing into the present (See Table 4). This was a very high proportion indicating that domestic violence was

⁴ Social workers that I have trained, who work alongside Morning Lane have sought to attend training on family therapy courses provided by Morning Lane and have become excited about learning skills related to direct work.

one of the main issues that led to social services involvement. The violence was very serious, e.g. in one family the mother accused the father of raping her and putting a gun in her mouth (Case B). In another case the mother disclosed that the father tried to kill her in front of the children, had a knife held to her throat and was taken hostage by him with the children present. The children were reported to be traumatised by this into their future (Case C). In Case J the mother was actually murdered by the father. This was a particularly harrowing case that I was involved in, as I had assessed the mother's parenting capacities in two parenting assessments over a period of a few years. I had also recently assessed both the mother and the father (the murderer) in relation to the care of their baby, presciently raising serious concerns with the local authority about the potential for the mother to be murdered by the father. I had also assessed the Grandmother and Great Grandmother, therefore, I had been involved with the family extensively over a period of some years, gaining a multi-generational view of the family's problems. I had to give evidence in court whilst the father, suspected of the murder of his partner but not yet convicted sat watching me while in handcuffs and escorted by two prison guards. I revisit this case at the end of this chapter.

In 7 out of those 13 cases addiction was a complicating factor alongside domestic violence (B, D, I, J, K, M, P = 54%) and it wouldn't be difficult to predict that there is a high level of correlation between addiction and violence where one fuels the other or in the case of the mother's addiction, as a way to cope with the domestic violence. It would be useful to explore this further in future research studies.

Some of the worst violence occurred when the children were very young infants (9 families = B, C, D, G, I, J, K, M, P = 19 children).

In discussion with the mothers during the assessment process 9 women were able to remember significant abuse in their own childhoods through witnessing domestic violence between their parents, as very young children or experiencing violence themselves.

Evidence of domestic violence was taken from more than one source including social worker's accounts, police reports, or most movingly, verbal accounts by the children during the assessment. 10 of these cases. I would describe as having involved extreme violence and/or highly conflicted relationships where violence is known to have occurred in front of children (this is only what we know about). Some of the violence was very extreme and was raised by the children during the parenting assessment (5 families).

Over half of the serious violent incidents occurred when the child was a very young infant. This is likely to have had the effect of traumatising the child, interfering with the emotional, physical and psychological development of the infant and the mother's capacity to be emotionally available due to being preoccupied by the violence, and the

resulting fear and trauma. Younger children tend to exhibit greater damage than older children (Meltzer 2009). Trauma at a very young age is hard for the child to recall when they are older, therefore the child is less likely to be able to think about it objectively or to process it emotionally, resulting in longer term psychological problems. As previously mentioned, mothers may cope with the breakdown of their relationship by turning to drugs or alcohol, thus compounding the effect by neglecting the infant (Youell, 2013).

Effect of Domestic Violence on Children

Evidence of the effect domestic violence had on children is encapsulated powerfully in this extract from the parenting assessment in Case P (Parenting assessments were usually written with very close reference to the case notes):

*I asked whether he remembered his mother being hit by Mr * and Kent confirmed that he was about 6 when this happened and he did see it. He remembered that she was hit on the face and there was a hole in her forehead, which bled all over the towel. I asked how this made him feel and he said sad. He couldn't say whether Mr * ever hit him. I asked what Mr * looked like, he said he called him * and he was bald with spots on his face. Kent pulled his arm back making a fist, as if to punch when he talked about Mr * hitting his mum. This reminded me of the actions of Dreyfus when he pretended he was going to hit me during contact....*

The meeting became very subdued when Kent told me all of this and whereas before he was half laughing when he told me things, as if very embarrassed, hitting his head with the cushion there was a very painful feeling in the room. I thought Kent was on the verge of tears and we had talked about some very difficult things. (Extract from parenting assessment)

Witnessing domestic violence did not only have a traumatic effect on the children. which may or may not manifest itself at some later date in the future, but it affected children's relationships directly in the present. In this case (Case P) the violence had an impact on the sibling relationships between half-siblings, as I observed rivalry about whose father was the 'worst dad' during an observation of contact:

During the next contact on the.....Dreyfus again teased Benjamin about being scared of his dad, asking him if he remembered the time he hid from him when his dad came to get Benjamin and Kent.....Benjamin teased Dreyfus again about his dad being a wife beater and at least his mum had said his dad never hit her. As a result I explored the arguments between Benjamin and Dreyfus further, explaining to Benjamin that if Dreyfus's dad had hit their mother then this was a sad thing and he should not tease Dreyfus about it. I told Dreyfus that if Benjamin was scared of his father then this was also sad and he shouldn't laugh about it. Dreyfus raised his fist to me, standing threatening me in a very aggressive manner and I told

him never to raise his hand to a woman, or anyone else for that matter. W (contact supervisor) informed me that Dreyfus is constantly getting into trouble at school for being aggressive and Dreyfus looked worried when W told him off and said he would tell his father on Monday. Dreyfus fell to the floor, on all fours and hid his face. (Extract from parenting assessment)

There was strong evidence of psychological/emotional harm to Dreyfus in further observations during contact:

Dreyfus kept kicking Wilma (his sister) in the face and she said it did not hurt. Dreyfus then proceeded to show off by kicking himself in the face and taking his shoe off and hitting his forehead with it. I told him not to hit himself and he said it did not hurt taking his shoe off and hitting himself in the face with it. (Extract from parenting assessment)

When children suffer violent projections from witnessing domestic violence the children can become violent themselves. Imagining what the children have experienced in these scenarios reminds us of Rustin's point about the human instinct to avoid of mental pain. It is rather disturbing to think about what these children have experienced and their experiences were downplayed in social work reports. To complicate matters for these children I also suspected sexual abuse by one of the fathers, as there were sexual innuendoes between the children when they were teasing each other which their mother was keen to quash.

Domestic Violence Current at Time of Assessment

In 6 cases I found evidence that domestic violence was a current issue at the time of the assessment (B, E, J, L, M, O). This has serious implications for the safety of social workers. These cases had a particular quality of pressure from the parents, or a tense and highly charged atmosphere within the home during visits. There was a feeling of covert threat towards me personally during home visits, which had a great impact on me emotionally (B, E, J, L, M).

For example, in case B, I had been asked to undertake a viability assessment of the child's biological father. Although the mother had reported domestic violence in the past about him and this was part of the reason for the local authority's involvement originally, this had been 6 years prior to my assessment. Therefore the significance of this information had become lost. So much so that the social worker did not mention anything about safety precautions prior to my visits. I naively undertook the home visit alone, visiting an area of London I was unfamiliar with. The father had a new partner with whom he had a 2 years old child. During the first visit I found out she was pregnant again. His 16 year old daughter from a previous relationship was also present

and all this gave me a feeling of safety and confidence. The first home visit went well and we had a rather long discussion about his past violence towards the birth mother. This extract is taken from my original assessment report for court:

When I asked if Thomas believed Kelis had been caught up in the violence and what impact he thought this had on her, he described an incident when she was just 2 weeks old. He said that she was screaming her head off for about 15 minutes with wind before Daniella went to see to her. He eventually went upstairs to see if he could calm Kelis down and when he went to pick her up Daniella grabbed her from him. He showed me how he reacted, raising his arm and said he 'went like this and boxed her,' thinking that her reaction was not right as it was his child. He said it felt like Daniella was trying to steal the baby away from him when he was just trying to calm down a stressed baby. Thomas said that Daniella had psychological problems and blamed him for everything. He said the police came as a result of this incident and he admitted of course he boxed her, as it was mad and no one would have reacted differently. (Extract from parenting assessment)

During further questioning there were hints at more recent problems with domestic violence closer to home, in his new relationship:

*Thomas informed me that they do have a good argument which sometimes can get a bit 'rowdy' and 'mad' but S will just walk away from it...(later Ms * let slip that she sometimes runs away). (Extract from parenting assessment)*

Despite the clear messages during this visit that there were continuing problems with Thomas's temper I undertook a second home visit. This time the atmosphere was very tense and Ms * opened the door with what looked like a fat lip, as if she had been hit in the mouth:

*When I visited as arranged at 3pm on Wednesday it was sometime before I was let in the home by Ms * who had a very raised and swollen lip. I could immediately smell cannabis and wondered if Ms * had been assaulted. Ms * informed me she had a cyst and had not been to the dentist about it yet. (Extract from parenting assessment)*

This was a highly tense visit and I worried about my safety. I thought Thomas was high on crack cocaine and I could see drugs and a weapon in the front room. The fear and adrenaline had the effect of paralysing my legs and I found it difficult to write my notes or stand up from sitting down, therefore unable to leave immediately. I did bring the visit to a quick end and managed to make my retreat. This was followed up with a referral to social services regarding the welfare of their current child but I was advised later that following an initial assessment they took no further action as Ms B denied any violence.

In another case (Case E) a new man was on the scene and this was someone the mother had married quickly in Africa when she went on a visit and who she then brought into the country. She had not told social services about this new relationship despite her son being in care. Therefore little was known about him or the impact he would have on the family. Most disturbingly Thomas put his hand down his trousers and played with his crotch behind his wife's head while I was talking to her during a home visit. I was later told by the social worker that Ms * had presented in court with a black eye. The children's guardian had reported there was domestic violence and they had subsequently separated. I thought that this explained the very tense nature of the visits and how shift and uneasy the mother was with me.

In Case J there was evidence of domestic violence the night before the home visit, as the mother had bruising on her arm:

When we went into the family home I felt scared. It was quite dark and no one was in the front room. I called hello and Matt came out of the bedroom, I thought looking red and a bit high. The social worker mumbled that he wasn't supposed to be there. He indicated Sonia was in the bedroom and we looked in. She was in bed and looking dazed, opening and closing her mouth, as if dehydrated. She hid a big bruise on her shoulder with her nightie. The social worker asked if I could give her a minute to talk privately with Sonia and I went into the front room with Matt. I asked if they had been drinking the night before and he said they had and T had been very drunk. They had gone around to her mother's as she was going to meet up with an ex who then didn't turn up.

He said that they had had a 'blow up' and the police had been called by a neighbour. Four policemen had turned up and had told him to leave. I asked about the bruises on Sonia's arms and he said they were grip marks as he had to stop her from self harming. He went into the kitchen and got the kitchen knife that she had tried to use. It was over a foot long and I felt my face drain with shock, thinking that I shouldn't show him how scared I was and hope that he would put it back quickly. I had seen this knife at the previous visit but had 'forgotten' about it. (Extract taken from work discussion paper)

These vivid descriptions of actual violence happening in highlight the dangerous and unpredictable nature of social work in the child protection field. It is clear that any evidence of violence in the present had a very immediate effect on the assessment recommendations in that I had no difficulty in recommending that the child should be adopted under these circumstances. The risk to the child was very immediate and real. This was in conjunction with an understanding of the chronic, reoccurring nature of the domestic violence, as patterns of this sort indicated the likelihood of continuing harm to

the child. However, some may have responded to their fear of violence by turning a blind eye or refusing to see the patterns indicating likelihood of harm.

The Ultimate Consequences of Domestic Violence - Murder

In an extreme case the mother was subsequently murdered by her partner (Case I). Sarah was murdered by Mani, who strangled her in his bedroom and threw her body in a canal. He was convicted of her murder and imprisoned. There was a serious case review following the murder where the police were criticised for not doing enough to protect the mother. The review also highlighted failures in social services, as Sarah should have been considered as a child alongside her own children as she was 18 when she first became pregnant. There was a change in policy whereby any new mother known to social services aged 16-18, would be accommodated alongside their child in foster care.

This case stands out for me over all of the cases due to the severity of the problems in the family and the length of my involvement in assessing the case over 6 years. It is not surprising that this case stands out as the mother was eventually killed by her partner, a man I knew quite well. It was also something that I envisaged happening and warned the local authority about, therefore the prediction is haunting in terms of its accuracy. This is an email I sent to the Head of Service and Social Worker months before the mother was killed by her partner;

Presciently just before her murder I wrote an email to her social worker and senior managers, raising concerns about her possible murder:

*"Dear * (SW),*

*I know we are in court with this on Monday for a final hearing re *,
I just wanted to highlight grave concerns about Ms *'s safety - which I am
sure you already know about.*

*S (Contact supervisor) told me on Weds that she had seen Ms * a few weeks
ago with marks on her face and she said * placed a bag over her head and
tried to suffocate her - she turned blue. She wouldn't do anything about this
and wouldn't leave him or talk to the police...*

*I wonder if we should involve the police even if Ms * will not - as we know
about a crime and it may be that this young woman ends up dead!*

*I don't think I am being over the top with this - perhaps after the court
hearing and the baby being adopted * may even become more violent - I also
know he is on probation for violence towards Ms * so perhaps he should be
in prison! He has a huge history of violence towards Ms *. I am worried it
will escalate after the hearing.*

I will see you all on Monday anyway and talk this through again, but I think this is an urgent matter that needs to be thought about separately in order to take immediate action.

The police can take action about domestic violence now even if the person does not want to take action. It would be terrible if we did nothing about this and did not safeguard M's safety. I know you all will be just as concerned as I am!*

*Best Wishes
Anna Harvey*

The relatively high prevalence of continuing domestic violence and the feeling of threat show the emotional impact of the work particularly when domestic violence and aggression is present during the home visits. It's important to articulate how the dynamics in these situations effect decision making.

Abuse and Trauma in the Parent's Background

By talking to the parents about their childhoods and undertaking Genograms during the parenting assessments, I found that abuse, neglect or trauma was a significant feature in the majority of their backgrounds (occurring in Cases A, B, C, D, E, F, G, H, I, J, K, L, N, O, Q = 15 out of the 17 cases). However, even this was likely to be an underestimate as in two of the cases (M and P) the information was unknown because the parents refused to engage in the assessment process, it was probably more like all of the cases. It is highly likely that the parents in these cases experienced some form of abuse or neglect in their childhood, given that it is such a huge feature in the parent's backgrounds as a whole. Therefore I evaluated this theme to be the most primary theme, alongside the fact that the cases involved marital conflict, and had been stuck over many years.

It appears to me that these factors, taken together, have a huge influence on the way parents are able to care for their children in the present. As Woodhouse and Pengelly (1991) suggest, we develop models in mind of 'parental figures' that derive from the models we were given by our experience of our parent, in combination with our own dynamic phantasy of how we experience those figures. This is not the same as saying that those who have been abused will go onto abuse, because although unconscious processes are at play, and at times a repetition compulsion is operating, we also have a conscious choice about how we parent and a capacity to provide something better for our own children.⁵

⁵ This point is made in *Ghosts in the Nursery* (1975) which I have already highlighted in the literature review.

The main analysis I arrived at, based on an examination of the themes, was that abuse and neglect in the parent's background resulted in emotional deprivation in the parent. This can in turn lead social workers who are in a position of sole responsibility, to become preoccupied with meeting the parent's needs, responding to their infantile projections and feeling overwhelmed by the chaos in the family. In line with Woodhouse and Pengelly's (1991) observation, it seems that social workers become like benign parents to the infantile part of the parents instead of working with their adulthood. This obscures thinking about the child's needs, either from the overwhelming impact that the projection has on the worker, or through a mirroring process, whereby the parent is unable to think about the child and the social worker just reflects this state of mind. This theme will be explored further in Chapter 4 and 5.

I have included some examples of the parent's experiences of abuse and neglect, which they described during the parenting assessments. Of course this information may have been given in a circumspect way, due to the context of why I was gathering the information. However, it does provide a snapshot of how awful many of their own experiences of being parented were. This is important, because it is my view that knowing this information provides the worker and organisation with a more empathetic approach to the parent and puts their actions towards their children into some kind of perspective. This was something I initially did not give enough consideration too in my reports and approach to working with the parents but which was highlighted in clinical supervision. This finding influenced what recommendations I made in later parenting assessments and developed a more empathic approach in my work.

This is a short extract from the assessment in Case C. Claudette informed me that:

*Her mother, Mrs * was 18 or 19 when she had Mrs * and her parents who lived in B*** separated when she was 4 years old due to domestic violence. Mrs * remembers her father as someone who was always out getting drunk, becoming violent when he came home both towards her mother and towards her self. Mrs * found it difficult to understand her experiences at this age but remembers her father hitting her mother. She described him as an alcoholic and someone who did not care who got in the way when he was drunk, experiencing his violence for herself. However, she was not sure about what effect this had on her and said her sister was too young to remember as she was only 1 years old... (Parenting Assessment)*

Claudette went on to tell me that when she was 13 years old she had a boyfriend aged 19 years old. At the age of 15 had a 28 years old boyfriend, becoming pregnant by him at the age of 17. She left home when she was 15 and said that her parents objected, but were unable to do anything about her choices. She said that violence began in her pregnancy when the, much older, man hit her. She emphasised his brutality by

describing how he hit her puppy with a broom handle. Claudette's partner then went on to hold a knife to her throat in front of the children. Then her next partner, the father to Coco was violent towards her children. It was not a huge leap of the imagination to believe this to be a replaying the trauma of domestic violence from her own childhood with her own children and she tentatively accepted this as a possibility during the assessment.

In Case D Rena describes her relationship with her mother and abusive experiences of being parented. It was a huge achievement to gain this account from her as she was highly evasive. None of the other professionals were able to engage with her and had given up on trying to arrange home visits. She was extremely difficult to meet, but through perseverance, I undertook a number of visits to the family home, gaining a much deeper picture of her background and current family life:

She explained how her mother took her to cabarets she performed in, when Rena was a young child, but would often leave her as a baby to be cared for by her 10 years old sister, leaving them at home alone. Her sister would change her nappy, bath her and as she got older, got her ready for school. Her mother 'pushed her' to do jazz and ballet but became really angry when she was 5 years old, as she could not do the shuffle.

Rena remembers running away from home with her brother when she was about 6 or 7 years old in her night dress. They were on their way to her Grandparent's home but were picked up by the police and brought back. Her mother threw her out of home when she was 8 years old when she had no shoes on. She remembers her mother was cruel to her and always told her when she was growing up that her father had wanted her terminated. She remembers that her sister was pulled around by her hair and called a 'slag' by her mother, who wanted to use the mirror herself.

Rena explained that her own mother was unwanted by her parents who wanted a boy. They called her a name that could be associated with a boy's name and adopted a son after her mother was born. She describes her mother being jealous of the favoured adopted son... (Parenting Assessment)

In case L, Mr D informs us that;

Mr D was born in Nairobi, Kenya and moved to England in 1971 – 1972 with his parents and siblings when he was 20 years old. He has informed the Social Worker that he experienced a high level of physical chastisement from both parents as a child and in turn was physically and emotionally abusive to his younger sister. (Parenting Assessment)

In a disturbing account of her mother's history in Case N, 'Samantha' describes a really unusual family history:

*Samantha explained that her mother was originally from ***, Middlesex but went to live in South Africa with her husband 'Tom'. She described her mother as being rich when over there, having a 'big house and servants, eating caviar and drinking champagne'. She had hairdressing shops over in England, which she sold and bought a furniture business in South Africa, which became financially successful. Samantha informed me that her mother caught her husband 'in the act' on the sofa with his secretary. Apparently she shot him twice, aiming for his chest to kill him, but missed and shot his arm then she 'beat up the woman'.*

Samantha's history was marked by abuse and neglect. Her mother tried to kill herself after she shot her husband. She was depressed. She married Samantha's father and they always argued. She used to be in the middle. She remembers her mother being distant as she was always ill or working long hours. She was sexually abused by her half brother from the age of 7-14 years old. (Parenting Assessment)

Abuse and neglect may not be the only factors leading to emotional difficulties in adulthood and problems in turn with parenting. Traumatic experiences can have a lasting effect, particularly if there is no helpful adult around. Often when one parent becomes ill or dies the other is quite understandably distraught and unable to care for the child at that point. Also trauma may occur in an emotionally cold environment where there has been a failure of care already. Traumatic effects of an accident are described in Case F by the mother:

*Ms * said that her mother had a brain tumour in 1995 when Ms * was just 13 years old and remembers that she blacked out while driving and subsequently crashed into a bridge. She was given 2 weeks to live as a result of her brain tumour but recovered after spending 8 weeks in hospital. Ms * said that this was a big shock and she was not allowed to see her mother for 4 weeks while she was in hospital. Later when asked she said at this time her 'world was torn apart' on hearing this news and her father went to pieces. She became tearful at this point, saying that although the school knew 'no one bothered' and she received no counselling during this traumatic time. (Parenting Assessment)*

Emotional Deprivation and it's Effects on Decision Making

In Chapter 4 the mother's accounts of their childhoods are as equally horrific as the ones above. Some are abusive and some, like in Case K are traumatic and neglectful. Chapter 4 will describe the effects of emotional deprivation arising out of abuse, trauma and neglect on the parent-child relationship. Chapter 6 includes a wider discussion about the consequences of understanding the parent's background and the effect of emotional deprivation and abuse on decision making.

4. The Psychodynamics of Decision Making - Case Studies

In this chapter I describe and explore dynamic processes in three cases, which I have identified as having an affect on decision making. The dynamic processes include: The emotional deprivation in the parent and the projections arising from this deprivation; Emotional deprivation in the child and a projective identification with this deprivation by the social worker; And borderline dynamics and the affect of the mother's changes of mind on decision making. These case studies also explore the dynamics behind removing a child at birth, multiple placement breakdown, and organisational mindlessness.

I will describe these processes in depth by combining the retrospective data gathered during the parenting assessments from Part One, alongside data from the interviews with the social workers from Part Two. I will also share my countertransference responses consisting of memories, thoughts and feelings arising from the parenting assessments and interviews. I will examine the theme of inter-personal relationships and subjectivities in depth. Clinical supervision provided me with further articulation of the unconscious processes that may be occurring in each of the cases.

Case J: Emotional Deprivation in the Parent

“The parent, it seems, is condemned to repeat the tragedy of his childhood with his own baby in terrible and exacting detail.” (Fraiberg et al, 1975)

I chose this case as it demonstrates a common unconscious process that influences decision making in cases where emotional deprivation in the parent is apparent. It reveals the psychological and emotional toll that working with deprived, neglected and abused adults has on the worker, and the overwhelming nature of projections which have the potential to cloud judgements. In this case the social worker becomes overwhelmed with the mother's needs and loses sight of the child.

Case J involved a 5-month-old baby called 'Lola'. Her mother, a white UK woman called 'Sonia' was 19 years old at the start of the assessment. Sonia was in a relationship with 'Matt' a 44-year-old, white UK man who was not the father of the child but wanted to care for the baby as his own. Sonia had a long and sad history of being in the care system. Matt and Sonia had problems with drug and alcohol addiction, which included

heroin, alcohol and crack cocaine use. Matt was a long term heroin addict and had a long criminal history. Lola was accommodated at birth and was in short term foster care at the start of assessment. She was removed from her mother's care due to concerns about Sonia's chaotic lifestyle, vulnerability, her long history of care and drug taking behaviour. She had tested positive for cocaine on three occasions during pregnancy and as a result Lola was kept in a high dependency unit for a few days after her birth for breathing difficulties. Sonia was having contact 5 days a week; 4 days in the foster carer's home, and 1 day in a contact centre alongside her partner, Matt. Sonia and Matt's attendance at contact had been very irregular.

When I visited Lola in the foster carer's home, she was snuggled into the foster carer's chest. The foster carer kissed the top of Lola's head as we spoke. The foster carer described Lola as being adored by everyone in the household. She called her *'lovely, adorable and priceless'* (Parenting assessment dated 26.06.06) I include this snippet from the parenting assessment as there is very little further information about Lola from the social worker in the interview, an issue I will return to later in this section. It is also in stark contrast with Sonia's childhood.

Sonia's Background

Sonia suffered a very disturbed and deprived childhood. She was known to social workers from birth because of chronic neglect, domestic violence between her parents and sexual abuse. Her mother and father were alcoholics and drug addicts. She remembered her mother being *'bruised black and blue'* by the violence and punched until the *'blood poured out of her.'* (Parenting assessment dated 26.06.06). Sonia's parents separated early and she was looked after by her father until he died when she was 12 years old. She was moved to her paternal Grandmother's care but she was soon unable to cope with her behaviour and Sonia was accommodated by the local authority as a consequence. Sonia experienced multiple placement breakdowns while in care and she was mainly out of the control of adults around her. It was suspected that her mother prostituted her during this period of time. During the assessment Sonia described her mother as someone who smoked heroin regularly and who also took crack cocaine. A year before my assessment, the leaving care team had discharged their duty of care towards Sonia when she was just a few months pregnant.

During the parenting assessment Sonia talked about her own deprivation at birth. Sonia described being born prematurely, weighing just 2lbs and *'big enough to fit into her father's hand.'* (Parenting assessment dated 26.06.06). This was due to her mother's drinking and smoking heroin throughout her pregnancy. As a result she remained in a specialist baby unit for 13 weeks for concerns about her breathing. Despite this she was allowed to live with her parents (unlike Lola). She said her parents would play *'pass the*

parcel' with her when she cried (*Parenting assessment dated 26.06.06*). This scenario uncannily echoes Lola's early neglect during pregnancy.

Mother and Baby Relationship

Sonia met with me a number of times during the assessment and we had a benign but tenuous relationship. She would be incoherent in some discussions, coming across as extremely timid, frightened and confused. However, whenever Matt joined her in the interviews she became a more open and relaxed person, talked coherently, showing no signs of her previous bizarre behaviour. In some ways I felt he contained her anxiety as if she relied on him for some level of stability in her mental health. However, their relationship was complicated and there was evidence of violence:

Sonia had small bruising to her face, around her jaw, which looked like finger grip marks. When asked how she got them she replied cryptically 'you would think they were grip marks wouldn't you?' (Parenting assessment dated 26.06.06).

During one home visit Sonia told me that she had a '*blow up*' with Matt the night before. She was obviously very hungover and had bruises on her arms. She was due to attend contact that morning but had failed to turn up. She said she had been drinking alcohol the previous night as she had '*wanted some excitement*' having planned to meet up with an ex-boyfriend. She waited for him at her mother's house while Matt took crack and her mother smoked heroin. When they got home Matt said the police were called by a neighbour and four police men had to '*drag him off*' throwing him out of the house (*Parenting assessment dated 26.06.06*). The social worker informed me there was a used condom in the bedroom when she went in to talk to Sonia. Terrifyingly, Matt showed me a very large kitchen knife which he said Sonia had tried to cut herself with the night before and this was the reason they had been fighting. This made the blood drain from my face and left me shaken. The social worker was in the bedroom with Sonia at the time and did not see this interaction.

Sonia had a disturbed relationship with Lola and found it hard to relate to her with any sense of reality. There was a painful observed contact where Sonia found it difficult to connect with Lola (this extract is taken from a second parenting assessment I wrote):

Sonia looked a bit lost with Lola and placed her on the bean bag. She looked worried, looking at me and asking if Lola was ok like that. When Lola began to complain Sonia said she did not know what was wrong with her and laughed nervously when Lola cried. She commented that she thought Lola was sliding off the bean bag but did not respond to her. I asked Sonia if she thought Lola knew them very well, as they had missed so much contact and she responded 'she does not seem to'. I stressed the need for her to come to

contact regularly so that Lola could get to know her. (Parenting assessment dated, 24.10.06).

Throughout the rest of the contact Sonia picked Lola up when she was sleeping, panicked when she woke up, then put her down when she was awake and needing comfort. Sonia would rock her in the car seat with too much force and place toys into her face, spinning them around. Lola became hot and bothered and then vomited. There was a lot of underlying aggression in the contact towards Lola. Sonia said bizarrely that she was glad Lola ‘*wasn’t a boy with his penis hanging out*’. She also said that she wanted Lola to be a ‘*friend*’ to her. Lola was inconsolable towards the end of the contact and she was handed over to me to calm down. Sonia never attended contact again.

Factors Influencing the Social Worker’s Views and Decision Making

The social worker ‘Mina’ was quite protective of Sonia during the parenting assessment and seemed distant and cut off from me, even hostile. She had been described by her managers as wanting Lola to return to her mother’s care at birth. Although the managers believed that the social worker did not ‘get’ the concerns about the parents, she describes the opposite during the interview, saying that Lola was at risk of *dying* if she was left in their care. It may be that the assessment helped her to see the concerns more clearly and changed her mind. However, it also transpired during the interview that she felt acutely sorry for the parents and did not feel they received the support they needed from herself or the organisation, as the focus had been exclusively on the child. At the beginning of the interview she highlights the mother’s deprivation immediately:

...and Sonia herself had been in care as a child (that’s right yes) so she was very, very damaged and a very vulnerable, vulnerable young lady. (Interview with social worker).

The social worker quickly goes on to reveal what it is that she really disagreed about with her managers, providing a different perspective on the dynamics behind the case:

But I also, I, I..the thing I struggled with in this case was that Sonia had so many complex needs and sometimes I felt like I wanted to support her (yes) but I couldn’t, (yes) I just thought that I was stretched to the maximum (yeah yeah) and, I found that very difficult {higher at the end} you know...? (Interview with social worker).

Mina is describing a feeling of being overwhelmed by the mother’s level of need and deprivation and an acute feeling of inadequacy. This results in anger towards her managers for the decision (the organisation’s and her own) not to offer support to the mother. Without knowing the manager’s view it is difficult to know if this is Mina’s perception and whether she was in fact prohibited from helping the mother.

It is obvious that there are unspoken views and deep feelings about the case, as there is a high level of awkwardness and tension at the start of the interview. There is a discordant feel to the interview, where Mina is not prepared to validate my memories of what had happened or the significance of what I bring attention to. Perhaps at this stage I am identified in her mind with her managers who she is still angry towards. However, the interview provides the space for Mina to bring her more hidden views and feelings out into the open and she begins to open up about her experience of the case. She describes the impossible position that she felt placed in as a newly allocated social worker, having to tell a heavily pregnant woman her baby was going to be removed at birth. I was very surprised by Mina's revelation, I had not appreciated her experience of the case up until then. I had made a number of assumptions about her being either incompetent or difficult, as I had previously found her rather cold and cut off from me and had been told by her managers of problems they had in communicating with her. Therefore the interview allowed me to learn something completely new about the case. Mina tells us about her experiences:

Mina: yeah I did feel very, very sad working (yeah) on that case, because, you know I think one of the other things was when Sonia was pregnant no one had told her that the child was going for adoption, so when I got the case I had to tell her and I think she was, possibly eight and a half months pregnant (oh my god), on the first meeting and I, I felt that was not very well done by the department (yeah) I think they could have been a bit more up front (yeah) and may be the planning could have happened much more before, to give Sonia some time [...] literally about 4 weeks before she was due, or 5 weeks (oh god) it was very late into the pregnancy which I found, I wasn't very happy about that, because you kind of ass- when you're starting your relationship you're kind of starting with that barrier that you are going to be removing this child (yeah) and Sonny (nickname) wasn't aware of that (yeah) so she was eh, scrimping and saving money to buy things for the baby (yeah). Fair enough they weren't great things but it was still somewhere, some starting point. So when I got the case I told her and told Matt this is not going to be happening and that was very distressing (yeah). (Interview with social worker).

The following extract from the interview beautifully captures an idea of Sonia projecting herself as a baby, an infantile part of herself is projected at the social worker, who as a mother herself responds in a maternal way towards the child-mother. She describes the awful dilemma she feels about wanting to care for the mother while apparently being told to remain exclusively focussed on the child:

Mina: I think ideally we should nurture and support the mother (yeah) because the mother's a child as well but, I know our focus is to get the child away, make the child secure but what about the mother's needs (yes) and support that mother needs, because I think if someone had given Sonia a bit of time to may be have some pampering for herself (yeah) to raise her self

esteem, focus on her, it might have helped her in her future (yeah) just make her a little bit more aware of things and because she was just so, I have worked with a lot of women but I would say she was one of the worst cases that I had ever worked with and you really felt this wrench, and I did talk to my manager about that in supervision, saying that I am really struggling with who's needs am I meeting because obviously I knew my needs were the child's but I just felt, what is going on here (yeah) because I, she was a very damaged, very sweet naive woman, and she was a woman in a child's body you know with a child's mind (yeah definitely) and I don't know if the depart, I don't know if we have enough resources and time, but ideally it would have been nice to support her and to help her, because I think very basic things, like sometimes I would go to the flat and she hadn't eaten (yeah) and you know, it was 2 'o' clock in the afternoon and she was still in her pyjamas and she was mmm (noise of sucking thumb) sucking her thumb and the flat was in disarray and I said well have you eaten today (yeah) oh, I'm not sure when was the last time I ate and then I would then be looking in her cupboards just for some simple, bread and I know that's not my role but I thought how can you ignore that. (Interview with social worker).

The social worker cannot ignore the vulnerability of the mother who is crying out for maternal care herself. The power of the projection means that she can't think about the real baby, Lola, because she has a more urgent competing 'baby' in the mother to care for. The neglectful, cruel mother is now the local authority who has made her unavailable to care for the mother as she has to focus on the 'real' child.

Seeing the Child

What is really stark in this interview is the paucity of information about the actual baby, Lola. There is little mention of Lola in the interview and she fails to be described in any depth. What little that is talked about is elicited by me through placing quite a lot of pressure on the social worker and the discussion about what happened to the child takes up a tiny fraction of the interview. The mention of the child is fleeting and extremely difficult to extract from Mina. This interaction left me feeling very awkward and at a loss to know what was going on:

Anna: So Lola is eh, you wouldn't have anything more to do with Lola, (no) do you get any information through from...

Mina: ...Just very little information from the letter box court lady or that we have had this update but not very much really

Anna: So what about her development, do you know anything about

Mina: no, I, no, no

Anna: Don't find out very much about that

Mina: No - I mean the letters aren't very detailed and they are only twice a year, they're not, you know (ok) there was a lovely picture of her in a field, just standing there looking very happy but there really wasn't much else. (Interview with social worker).

Just towards the end of this quote it appears that Mina softens, allowing herself to show the tiny appearance of warmth in relation to the child and an image of her standing in a field looking happy emerges. However, it is a very brief description. In my experience it is highly unusual for a social worker not to know or take an interest in a child once they are adopted and I found it very difficult to believe that there was no other information available. It is in stark contrast to interviews such as in Case F, K and M where the social worker knows even tiny details about the outcome for the child. It is as if Mina is emotionally very distant and cut off from the child's experience, heavily defended against any connection or awareness of her as a real person. Perhaps again this is related to guilt, and Mina feels she is not allowed to care for the baby or take an interest in her as this would be disloyal to the 'child' mother. Another possibility is that Mina is resentful towards the baby for getting all the care in contrast to the baby part of Sonia who remains neglected. Also she may be resentful towards the baby, because if it wasn't for Lola, she wouldn't have had these awful experiences. It reminds me of the description Mina provides of the relationship between the mother and child at birth, where Sonia is unable to look at Lola and which I will relate later in this chapter. Perhaps Mina is mirroring Sonia's detachment.

From Defended and Discordant Towards Connection

It is only when Mina opens up about her rather traumatic experiences that the interview becomes more relaxed and I get a sense that we are connecting over a shared understanding about the case. Mina warms up towards me when she is able to share her underlying, hidden views and anger towards the organisation and some of her memories about what the case entailed. She seems to relax and begin to trust me. The extreme nature of what the job entails is vividly depicted by the social worker later in the interview:

Mina: Yeah I mean, again, I found that very difficult because as soon as she gave birth they told me to go down to the hospital, which I did, but I found that really, really intrusive (yes) very intrusive, because mum and Matt were there [...] and it was actually quite horrible because when I went into the labour ward, she had just given birth, and so my timing was not great and um, unfortunately she was bleeding, because she had just had a baby and Matt was helping her with the sanitary pad (pause) and I thought, oh my god, this is too intimate and too intrusive for me and I had to stand away from them and had to tell them you carry on with what you are doing (yes) and Matt took her into the bathroom and helped her, I think he helped her

get a new sanitary pad and it was, it was very uncomfortable (oh the poor thing) for me, I know it was really painful.

Anna: ...and like did anyone come with you (no, I was on my own) you had to go by yourself [...] it's kind of pretty horrific kind of stuff too and it's quite visceral isn't it

Mina: Yeah and Matt, Matt knew what I was doing there because I said I've come to take Lola or you know, I think Lola, they'd put her on the ICU ward or something because there were some issue so they had sent her up there, so I [...] said look, you know what the plans are, I just want to reinforce that, and they were both, obviously they had just had the baby and they'd been quite emotional and Matt was on quite a high as well as he had been there for the birth and so he had witnessed that and erm, Sonny (uses nickname) was a bit subdued and (pause) a little bit out of it and I thought what am I doing here, I felt very uncomfortable, erm then Sonia came back and the nurse said would you like to go and see the baby, she was put in a wheelchair because physically she wasn't feeling great so they put her in a wheel chair and we took her down to the unit but Sonia, Sonia didn't look at Lola, she wasn't able to look at her and Matt, Matt was making comments about her hair and eyes, very animated as if he was the father and I was there with my little camera taking pictures, but again that was a very intimate, intrusive situation (yes) and just question what I'm doing there (yeah) and I know, we have a role, because of life story pictures but, it just really didn't feel right

Anna: And did you ever get any debriefing for this kind of stuff, did anyone ever say, you know, what is this like (no) emotionally and stuff (no)

Mina: I, and I mean I'm a mother as well and I'd had two children before so I knew (yeah) it's an emotional, critical time...because it was literally Anna, she had just given birth, because the bed had still, it was in the labour ward on the ward where she had given birth. I think she may have been moved to one of the rooms at the side, it wasn't actually the labour, the maternity ward but it was a room at the side of it and she was, I'm telling you that she was changing her sanitary pads, because you could hear that she was removing the label, it was that intimate, and I felt what am I doing in this room, (god). It felt really bad and I, I hated saying to them oh you know why I am here don't you and they, what are they supposed to say to me. (Interview with social worker).

In this extract Mina is obviously traumatised by the feeling of intrusiveness and is aware that her presence was a reminder about the removal of the baby, at a time when the parents should have been bonding with the child and celebrating. She seems to indicate that she caused the distance between Sonia and her baby, as the mother doesn't look at Lola. Perhaps this gave rise to feelings of guilt and acute destructiveness of the bonding process. It is possible that this is why Mina is unable to celebrate Lola's achievements and development in her new adoptive home. She has a camera at the birth

to record photographs for the life story work, and then she is unable to recall much about Lola except a vague photograph of her in a field.

Mina's account of what her work entails makes the rather banal phrase 'the child was removed at birth' take on a whole new meaning. Practice, in defensiveness, has become sanitised and reduced to empty, dehumanising stock phrases, with all the blood representing emotional pain, being wiped out of the picture. It is obvious that Mina was traumatised by such an event.

Clouded Judgement or Keener Values?

However, such understandable sympathy for the parents and the possibility that she felt intense guilt does seem to cloud Mina's judgement about her own and other professional's safety, leaving her cut off and unable to recognise their disturbance, or the danger they posed. For example, mine and Mina's experiences of Matt couldn't be more different, she feels a huge sympathy towards him, whereas I saw him as someone out of control and potentially violent due to his use of crack cocaine (In my practice experience it is a drug associated with aggression and unpredictability):

Anna: Do you remember that home visit we went to (yes, yes) and I remember you being in the bedroom and remember Sonia having bruises kind of on her face (yes) and on her arms and erm, like while you were in the bedroom Matt showed me a knife

Mina: Yes I remember that

Anna: Do you remember that (yes)

Mina: And you were really concerned weren't you about (just the risk) risk to the workers (yeah) and it was decided that I wouldn't be doing any home visits (was it, laughing), yes, it was, after you were a kind of bit more vocal about 'risks'

Anna: Because I think there was er, a lot of crack cocaine use wasn't there? (yes, possibly from Matt) I thought Matt was high, you know he wasn't threatening us with the knife but it felt very unsafe (yes) going into the home, those kind of (with that risk) into that situation basically

Mina: Yes, so (moving on quickly) the local authority now doesn't have a very active role, it's just to facilitate letter box (yeah), I do know that the adopters do send pictures and letters (yeah) but I don't know if Sonia does reciprocates (ok).

Mina seems to change the subject, leaving me feeling on my own with my concerns about what she terms 'risks.' I return to this subject later in the interview as I was surprised at how different our views seemed to be and wanted to explore this difference of perception further.

Anna: And, what did you think when I kind of made a fuss about you going to the home visits saying that it was unsafe, did you think I was, did you think that was right or (erm) – or did you feel unsafe

Mina: To be honest I didn't feel unsafe, I never felt unsafe, because I think Matt, he did respect what I was trying to do, so I didn't feel that I was in a risky situation, because, yes, he did kick off a couple of times, he was quite aggressive but I think he was annoyed at the situation, the fact that he felt helpless, he didn't have much control, that things were moving ahead and he couldn't do anything to stop that, but I, I didn't feel that he was ever threatening or abusive to me [...] he was never, he did kick off with me, he did shout at me a few times but I didn't feel it was something that scared me or frightened me, you know, sometimes you meet these clients and they give off these vibes, and you think, ah, ah, I'm not going to go there, but I didn't ever feel that I shouldn't go to the flat (yeah), I know that after you raised your concerns my managers did say don't go there on your own and so for a while I didn't...(Interview with social worker)

Mina's experience of Matt is rather different from mine, as during the home visit in question he 'showed' me a huge kitchen knife and my response was to feel the blood draining from my face in sheer terror. Mina was in the bedroom with Sonia at the time so perhaps did not have the same reaction as she did not experience this encounter. The social worker ends the interview with gratefulness towards Matt:

Mina: Matt her partner did say he realised that my role was very clear cut and he didn't have any grudges or any animosity towards me (yeah, yeah) which I really admired in him, because it must have been very difficult. (Interview with social worker)

Compared to my view of Matt, Mina views him as a more benign figure, responding to a good experience of him and turning a blind eye to the more disturbing aspects of his character. For example, Matt was a man who regularly took crack cocaine, injected heroin, physically assaulted Sonia, took advantage of Sonia's vulnerability in a sexual way, had conducted a relationship with her mother when Sonia was 12 and had a long criminal history. However, Mina experiences a part of Matt which is rather benign and gratifying to work with. This possibly echoes a dynamic identified in Case A where the worker responds to an idealised part of the client which they project and for that reason fails to see the disturbance, which has become split off and denied. Perhaps the flip side of Matt, an aggressive, potentially violent man is experienced by me. This echoes Foster's point about splitting, in her account of the psychodynamics of working with a female drug user (Foster, 2013). It must be extremely difficult to keep both aspects of the parents in mind, their vulnerability and victimhood of abusive childhoods, and the aspect of themselves as perpetrators of abuse in the present.

Countertransference

One of the strongest experiences I had when working on this case was an uncomfortable feeling of discord between me and the social worker, which left me unsettled for a long time and was only resolved through the long and revealing interview. I had a strong feeling of awkwardness and a sense of a dread arising out of an unspoken disconnect between us. Her feelings of anger and hostility towards her managers probably extended to me, and a feeling that I also represented the managers authority. Therefore a sense of covert ambivalence predominates the initial part of the interview, demonstrating how aggression can infiltrate working relationships. I remember the relief in the interview, when she shared her views about the difficulties of working on the case and a shared understanding of the emotional impact the work had on her. Mina complains that her supervisor didn't understand the confusing feelings, such as the push and pulls from the case. Perhaps if she had been understood, she may have been able to get on with her work in a more straightforward way. The implications for practice and the need for debriefing seem obvious, a space needs to be provided in the form of reflective supervision which attends to the emotional aspects of the work.

The discord felt between Mina and I during the interview and our lack of shared agreement about facts could be understood as similar to a psychotic experience. We could not agree on relatively straight forward facts about reality i.e. was it unsafe to go into the house after Matt 'showed' me the large knife. Was Matt an admirable character? Was Sonia a '*sweet and naive*' woman? I wondered if the mother's psychotic and borderline states of mind were somehow being mirrored in the relationship between me and the social worker and prevented a shared sense of reality about the facts. However, this experience also highlights the sheer scale of uncertainty involved in assessing risk, where there are multiple subjective experiences involved (some of them highly disturbed). Reality and facts never appear straightforward and can become hotly contested.

The interview however brought us together and there was a shared, mutual understanding and sympathy about the case towards the end. I think Mina appreciated the space to talk about her feelings, describing how no one ever asked her how she felt in another case where the mother who she was working with had killed herself (Her first case as a newly qualified social worker). Mina informed me that she spoke to the mother on the Friday and when she came into the office on the Monday she found out she was dead. These cases stay with social workers for a long time afterwards, traumatising them and affecting future decisions about children for good or bad. The shock and guilt of a suicide could have left Mina paralysed and unable to think or act decisively about the child. It is another contributing reason for her to be preoccupied with the parent, wondering whether she was going to live or die.

Case K: Emotional Deprivation in the Child

This case study presents the effects of a child's emotional deprivation, grief and loss on the social worker. It also tries to capture the influence of dissociation on organisational dynamics. It also shows the progress from an emotionally detached, highly defended position towards connection. It is argued that thinking about the child's longer term needs is impossible for the social worker who is occupied with lurching from one bereavement to the next. It takes a different part of the organisation (the adoption panel) to contain the wilder elements of the case and provide the capacity for thinking.

Lee was a dual-heritage child, aged 5 at the start of the assessment. He was 10 when I interviewed the social worker. He had been living in short-term foster care under Section 20 CA 1989 for over a year when I began the parenting assessment. He had been accommodated following an incident where his mother was found in a comatose state due to a heroin overdose. His mother, 'Maude', was a single, white UK woman aged 43. His father was of Pakistani origin but he was not involved in the assessment. Lee had an older half brother aged 21 at the time of my assessment, but I never met him, although he was asleep in the bedroom of Maude's house during one home visit. His shadowy presence was hovering around in a ghostly way during the assessment.

Maude's Background

Maude's description of the relationship she had with her parents highlights an emotionally damaging early adolescent environment. Maude is not totally explicit about the extent of the deprivation she suffered as a child, but given practice wisdom we could infer from the tragic pull towards chronic addiction throughout her life, that her childhood contained emotional deprivation. She seems cut off from the awfulness of her experiences as a child, saying she had,

*A lovely childhood where they enjoyed many holidays with her parents.
(parenting assessment, dated 03.08.06).*

Maude's father died when she was aged 13 years old after being ill for 3 years with a rare illness. She said it was a 'relief' when he died, as he had been suffering for some time (Parenting assessment, dated 03.08.06). Maude left school to look after her father when he was ill:

Maude remembers helping her mother with her father's care, as she was still working 3 days a week. She would take him 'in and out' to hospital appointments, to get his paper, helping him with his commode [...] She explains that it was painful watching her dad suffering and her mother was distraught. Her father did not want to go into hospital towards the end,

which upset her mother and she said she had to 'grow up really quickly.' (parenting assessment dated 03.08.06).

What does the phrase '*grow up really quickly*' mean to Maude? Was she able to mourn her father's death? Or admit to and feel the whole implications of her grief and despair? Probably not, as she infers that you *grow up quickly*, get over things, and act like an adult. As a young carer, I am sure her experiences will be shared with thousand's of children who do the same each day in Britain. Perhaps her relationship with her mother was not very supportive either, particularly if her mother was in a 'distraught' state herself, Maude's needs as a child may well have been forgotten.

Maude goes on to describe her relationship with her mother as '*fine*' and that her mother was '*firm but fair*'. She hints at physical chastisement saying '*they were strict in those days*'. She also hints at a distant relationship with her mother as her mother was away a lot visiting an older sister in Australia. She describes being closer to her Grandmother and Aunt than her mother. Tragically her mother died of a brain tumour when Maude was 15 years old. When asked how she coped when her mother died she said she '*just had to carry on*' and was very upset, thinking, '*why me?*' (Parenting assessment dated 03.08.06).

Maude developed a chronic drug and alcohol problem during her teenage years, smoking cannabis in school at the age of 14 and taking heroin when she was 19 years old. Her first boyfriend introduced her to heroin when she moved in with him aged 19. It is not difficult to make a link between her turn towards drugs as a way of coping with the deaths of her parents, signalling a flight from psychic pain. Maude had four successive partners with serious alcohol and drug problems. Two of her partners died of heroin overdoses in her front room (I sat on the same settee that they died in while I was visiting her for the parenting assessment). She found both partners slumped over, dead when returning home - one reading the news paper upside down and one with his lips turned blue (perhaps the similarity and repetitive nature of these events has the quality of the originating trauma such as the death of her father). Maude described being called '*unlucky in love*' by a coroner who looked into their deaths. Maude told me this wistfully, somewhat making light of the terrible story (Parenting assessment dated 03.08.06). It was not until after I left the home visit that I reflected on the shocking content of what she had said. I said half jokingly during the home visit that perhaps I should be afraid of being there. In clinical supervision my supervisor wondered whether she was unconsciously asking whether I was afraid of her dying. On further reflection this scenario also captures the dynamic of dissociation that is central to the unconscious processes of this case (Dissociation being central to the dynamics of addiction).

Maude had recently suffered from breast cancer although she had got '*the all clear*' following treatment. She also informed me that she had Hepatitis B, for which she was receiving no treatment. She developed liver cancer following the parenting assessment and she died quite suddenly after the Care Order was made for Lee. Lee's older half brother had died of a drugs overdose shortly before Maude's death. Then Lee's father died suddenly just after Maude's death, again just after the care proceedings concluded. Even Lee's dog died. All the family members died in very quick succession and information about their terminal illnesses came without warning to the social worker who somehow had to manage it, communicating these difficult things to Lee who was only 5 years old.

Decision Making Regarding Lee's Care Plan

Lee had been in short-term foster care on a voluntary basis for over a year before my parenting assessment began. Even the foster carer commented on the lack of planning for the child on my first meeting with her at the contact centre where I observed Lee with his mother (Parenting assessment, dated 03.08.06). It was difficult to understand why the care plan had been allowed to drift for so long. Cheryl doesn't explain the reasons for delay at that point. However, this was one of Cheryl's first cases as a newly qualified social worker and I recall her managers telling me they needed my help in order to progress the case, as Cheryl seemed to be stuck.

Cheryl explained to me that it was the legal department who were reluctant to progress the case to court because it would put the Local Authority in a 'bad light' i.e. Taking legal action against someone who was until recently very ill (Maude's breast cancer was very recent). Therefore, I assume that my input was also needed to gather the evidence that the problems with Maude's parenting related to her drug and alcohol use rather than her illness. This is despite the fact that Lee's accommodation was as a result of a serious heroin overdose in the first place, they thought she had died. There was an underlying wish to avoid looking harsh towards the mother, rather than having a focus on the child's needs. A lack of strategy in care planning and permanency were the organisational factors for the drift in care. However, there was evidence of unconscious factors in this case.

Lee's Accommodation

As mentioned, Lee was accommodated initially on an emergency basis as his mother was found in a comatose state after taking a heroin overdose. Although this was an unplanned move and an emergency placement, he went on to live with his first foster carer for over a year. Lee then moved to another emergency foster carer placement following allegations he made against his foster carer of being hit. His foster carer made counter allegations that he was dangerous around her new born baby:

Cheryl: *So then he moved to the respite carers, he was, that was the obviously choice, I want to say, almost, because he knew them and they had a space and that, he was with the [next foster carers] for about 3 years. (Interview with social worker).*

Remarkably, Lee remains in this, almost arbitrary, emergency short-term foster care placement for the next three years. This was a crisis led move that turned into a relatively long-term stay. It is possibly that this stay was a one of convenience while the social worker and Lee dealt with the successive losses he experienced in his family. However, Cheryl believes the standards of care the foster care's provided Lee were barely adequate right from the start:

Cheryl: *I straight away had concerns about [name of foster carers] really, urm, just basic things like the urm, they wanted for him straight away to be picked up and transported to school [...] because the mum was a stay at home mum but her children always came first so she couldn't pick Lee up [...] When I first visited the house Lee was not allowed to play in his bedroom and he didn't have no pictures of his family, he, his clothes wasn't in his cupboard erm, he didn't have like, any, the room wasn't child friendly, there was no duvet on the bed, it was just like a blanket [...] it was not homely, and I thought this is a 5-6 years old child, who doesn't have toys in his bedroom, it's an unfamiliar room, there is no bed lights [...] it was very cold and erm, there was a computer in the room which the older children were using for their for their home work [...] but with this family I don't think he ever got a hug or you know, there may be kind words, but not regular praising enough, regular interaction with him, not playing with him or anything like that, when you did ask them, when you did ask them to describe Lee for me, they couldn't, they could just say he's a lovely boy, (laugh) you are like that you know he is 6, what does he like to do (yup) oh we don't know, well does he like to ride his bike, he doesn't have a bike, (Interview with social worker).*

Despite the initial impressions the social worker was able to address these problems with the foster carers who are able to improve the physical care that Lee receives. After 3 years living with these foster carers, Lee was moved to stay with another foster carer on an emergency basis due to allegations he makes again about his carers hitting him:

Cheryl: *So, yah, and so the foster carers found out that their son had a brain tumour in amongst all of this [...] but after that you could really see the care really deteriorated and the old concerns come back (yeah) like, like, they really didn't do nothing much for him, he really just was there for ? and then he made about 3 allegations them regarding hitting (oh), so after the 3rd one erm, (pause) we said no, enough is enough now, really [...] and he was so unhappy, you could just see this little boy, so being, so unhappy [...] so erm and you could see him being just so unhappy you could see him just not being natural, laughing, smiling child, just being sombre really at the last*

stages, so we just decided, I thought to myself, we can't have him anymore there. (Interview with social worker).

Cheryl's description of Lee's distress is upsetting to read. Unlike her earlier disconnection with his experiences she has become connected with him emotionally and responds directly to Lee's unhappiness by making a decision. She moves from 'we' to 'I' in the decision making as a way of emphasising that she made a decision that Lee ought to move, owning and taking responsibility for formulating a decisive response. In this way she *grows up* as a social worker, acting not just as an agent of the organisation, always looking to her managers to inform her decisions, but as someone with her own agency and capacity, authorised to make decisions on behalf of the child. In other words she acts as a responsible parent and removes Lee from a harmful situation, which she knows is wrong.

Lee is then placed with a single carer who has, again, acted as his respite carer, therefore someone who is he considered to have a prior relationship with. The same fostering agency is used throughout this time despite the chronic concerns about standards of care across his two placements. The initial period with this third foster carer appears heavenly compared to his previous placement. Lee and the carer seem to make a powerful connection (described almost like a love affair). His care is child centred and of a very high standard, like he is a child being cared for properly for the very first time. However, the descriptions are rather idealised and the higher standard of care seems to afford the social worker relief from quite powerful feelings of concern about Lee:

Cheryl: *He went to respite with Hortense, black single carer, erm, no children of her own so he was the only child and she was just like brilliant (yeah) she was just, she took him to theme parks, to parks, he could do, she did child things with him (voice in wonder) [...] because she was, she just did child things with him where he never experienced that with the [name of foster carers] she just, you know, they went to arcades [...] she was a foster carer, she was short term though but what she did was brilliant, she wasn't working so she had the time, they lived in a cul de sac, there was loads of other children, she just allowed him to play outside and he made friends and it was just it was just lovely to see [...] and he was totally a different boy, so he enjoyed it (it must be a relief for you) and he cried (eh), he cried when he had to go back to the [name of foster carers] he literally cried (oh my) sobs and tears, and that's when we really realised that you know, he is not happy where he is. (Interview with social worker).*

The initial stages of this relationship are so good and idealised that we hear that Hortense even considers adopting Lee. However, optimism is replaced by despair again when Cheryl describes his behaviour as deteriorating with the new carer. His distress gets acted out in aggression which the foster carer feels unable to cope with. The initial dream turns into a nightmare as Hortense changes her mind about looking after him in the long-

term. It is possible that Lee, feeling a sense of stability and potential permanency with an emotionally responsive carer allowed his distress and aggression to be shown fully for the first time. It is not surprising that a child with his history would test the boundaries to destruction, replaying dynamics of rejection and 'double deprivation' deprived not only externally by the death of his family members, but internally by crippling defence mechanisms. Lee seems caught in a pattern of hostile dependency where he rejects carers who retaliate by rejecting him (Williams, 2005).

Lee moves to his fourth and final placement, the only move he makes on a planned basis. He makes a good attachment with his prospective adopters who see him as *'just a normal child'* (Interview with social worker). The system of care around him seems to have begun to take a longer and deeper view of Lee's needs and the potential adopters are provided with therapeutic help in order to make sure they are supported in order to understand the extent of his emotional needs. The adoption panel require them to undertake therapeutic work for a year before adoption will be considered. Thinking is therefore eventually restored in this case and the preventative work seems to be successful as there is no placement breakdown in that time. Although Cheryl describes being devastated that the panel do not agree Lee's adoption straight away, she is able to reflect on this being the best decision for Lee in the long run, particularly following the successful therapeutic work with the adopters, who were allowed to care for Lee as foster carers pending their approval. At the interview, Cheryl was in a state of anticipation as she was just about to re-present Lee to the adoption panel after the therapeutic support had been completed. It was highly likely that this couple would be approved and that meant they could apply for an Adoption Order for Lee through the courts.

There was considerable drift and placement instability for Lee in this case and the case study could almost be a classic example of the issues involved in multi-placement breakdown or lack of permanency planning. However I am interested here in the dynamics that may have led to this instability, which can be seen by looking at Lee's experiences in more depth.

Lee's Experiences

Lee has a seriously deprived history, marked by neglect and multiple losses. It is difficult to condense the narrative into this chapter as the social worker describes a period covering five years and the interview is over an hour and a half long. However, I have taken some extracts which represent key moments in his life.

Lee first came to the notice of the Education Welfare Officer, because he regularly missed school. One day she went to his house, as he had not turned up at school and she

found him unsupervised as his mother was asleep. However, his mother was asleep in a ‘comatose state’ and she couldn’t be woken up. This is the social worker describing the circumstances around his accommodation:

Cheryl: *We couldn’t wake her, so we had to call the ambulance [...] I called the ambulance, and he was just like a wild child playing outside, throwing stones at the buses [...] opening the door for everyone, it was just, cos although he knew me he was just, there was a communal area and he just went out there, out the front door just opening the door for anyone and he just played outside [...] well Lee said, Lee kept saying mum’s just sleeping so it was as if it was a normal thing for him to think that mum was just, you know you try and wake mum and she is not going to wake up (yeah) and I was like, he, he didn’t look distressed or anything like that and it, for him seemed like it was a normal, everyday occurrence (ok, yeah) that mum would be s-, this way you know and I can’t wake her, where for us it was like, the other worker, duty worker didn’t want to go in because she thought the woman was dead, whereas I knew the mum, I had to do this, I had to go in and obviously it was frightening... (Interview with social worker).*

Cheryl’s stumbling and repetitive words seem to reflect a level of speechlessness and inarticulation about the horror of the circumstances she is trying to describe. The description of Lee is of a ‘wild’ child, who is aggressive, out of control and disconnected from the reality of the significance of his situation. The horror is conveyed in the fact that the duty worker won’t go in as she thinks that Lee’s mother is dead. Later in the interview Cheryl goes on to describe the circumstances and feelings around Lee’s mother and brother’s deaths:

Cheryl: *...and then mum died, so it was that then, I had to tell Lee that his mum died, and then I also had to tell him that his dad, brother died [...] it was horrible, I had no idea how to do that. His brother he was, his mum he was, he did go to the funeral, he didn’t cry, he didn’t cry when I told him, he didn’t cry when we went to the funeral, he was very, very scared and child-like at that funeral. (Interview with social worker)*

Again Cheryl describes Lee as not quite connected up with the pain of his mother’s death, or the significance of what is happening to him. At such a young age his these experiences seem very incongruent with the level of understanding available to him and his ability to process such tragic life events. It seems like Cheryl has to do the thinking and feeling for Lee, making sense of the tragic events in order for Lee to know what is happening in a more containable, digestible way. Cheryl goes on to describe Lee’s father’s death, which seems to be handled by Lee and those around him in a slightly better way. There is also some sense of thought around Lee’s therapeutic needs:

Cheryl: *...so I got him a balloon from the shop, and I asked him what colour and he said the blue one, so I got him a blue one (oh) and he had such a big*

funeral which was, mum didn't have, she also had a cremation but it wasn't a big funeral, whereas dad's one was really big, and it was such a saving grace with the balloon because he had the balloon in his hand, so wherever he went I could see the balloon [...] there's Lee, there's Lee over there, because he wasn't that attached to me at this funeral because he actually knew the family, dad's family (oh) erm, he knew Grandmother and he knew Auntie so [...] so he was much happier to be mingling. (Interview with social worker).

Eventually Cheryl describes a child who seems to respond in more emotionally appropriate ways, and who is more in touch and congruent with the significance of events that are happening to him. Describing his stay with his new foster carer she says,

Cheryl: *...and he was totally a different boy, so he enjoyed it [...] and he cried (eh), he cried when he had to go back to the [name of foster carers] he literally cried (oh my) sobs and tears, and that's when we really realised that you know, he is not happy where he is*

Anna: *God, at least he was still able to feel something and allow himself to be*

Cheryl: *Exactly because he actually cried when he had to leave Hortense, he said I don't want to leave, I want to be here and um, she felt really sad. (Interview with social worker).*

It is my view that this new connection with the pain of his circumstances, together with finding a more responsive carer, coincides with the Cheryl's more attuned care of him. Having an emotionally available social worker and carer appears to trigger a crisis in Lee, where he acts out his anger and aggression with full force. It is possible that the feeling of being cared for properly for the first time stirred up his deepest needs and a level of pain he had not felt before:

Cheryl: *His behaviour really deteriorated with Hortense [...] really badly erm, he started to swear at her, kick her, no boundary, she couldn't control him um, she couldn't take him out any more because he was just screaming like a wild child in shops and it looked like she was abusing him kind of thing and she was like I can't manage this, so erm, she made decisions that I can't look after him long term because I can't sustain this long term, (Interview with social worker).*

Cheryl describes the play therapist's view about Lee:

Cheryl: *So Lee was one of their high priority cases for her to see, she was very, very, very upset [...] about this child, he was, she was just [...] she was saying the rage and the things she was seeing in play therapy was extraordinary and he would talk in baby voices and you know he would just not let her in, I think she saw him about 12 weeks and it was just, at one stage she was asking him if he wanted to return and he just said no, they just*

stopped and she said, um, because he was so aggressive and violent that she was scared for his safety and her safety so she had to stop it and she was like he needs to have a much bigger assessment done on him. (Interview with social worker)

Eventually it seems that Cheryl and the care system are able to recognise the enormity of Lee's problems and the damage his experiences had caused for him internally (some 4 years after being taken into care). It seems to coincide with Lee becoming more in touch with his need for a dependable, responsive carer. That fact that it took until then for her to recognise his problems, leads to my own thoughts about the case and the dynamic of dissociation, a psychological defence against anxiety, which involves extreme splitting. Lee's deprivation and vulnerability seem to be split off from awareness due to his aggressive presentation, which leads to him being rejected. Lee becomes enraged following the betrayal of his mother, who removes herself through drug and alcohol abuse. Then his subsequent carers remove their emotional availability, when his first foster carer has a baby, and then when the next foster carers turn towards their own son who has a brain tumour. Perhaps rage and aggression become defences against an unbearable grief which can't be faced by him or the system around him.

Countertransference

Before the interview, I remember feeling that there was something not quite right about this case. Lee had been in short-term foster care for over a year with no permanent plans having begun to be made. I immediately observed Lee as being a disturbed, distracted and unhappy boy on my first meeting with him (Case notes and parenting assessment). He was very angry with his mum who was late for contact. He threw a toy at her as soon as she arrived and refused to kiss her hello. He looked dishevelled and neglected in appearance. His hands were down his trousers for most of the session and he scratched at his crotch continuously due to eczema around his scrotum. The drift in his care plan was the first thing the foster carer pointed out to me when she dropped him off at the contact session. I couldn't understand why the social worker was unable to see the neglect in his care and the harm that the lack of progress in his care plan was having on him. It seemed obvious to me that the mother was addicted to heroin and alcohol, as she came to contact sessions smelling of alcohol and appearing to be under the influence of drugs, which inflamed Lee all the more. It was clear to me that she was not going to change and Lee needed permanency as a matter of urgency. It was also clear to me that he was receiving inadequate care from the foster carer, as he looked unkempt. I was seriously worried about a lack of progress for Lee and how disconnected his social worker seemed to be from recognising his distress, which was showing somatically through his eczema and agitation. These very quick judgements of mine were based on practice experience and contrasted sharply with the social worker's heavily defended approach.

This feeling of being somewhat nonplussed by the social worker, wondering ‘what she was up to’ and why she wasn’t acting, contrasted sharply with how I began to empathise with her during the interview. I thought she came across as quite child-like and overwhelmed herself. She was young and out of her depth in dealing with the extraordinary circumstances of the case, although anyone may have found this case extraordinarily difficult considering the circumstances. Towards the end of the interview I also found myself thinking how heroic she was, sticking with Lee throughout his awful life events in order to eventually achieve adoption for him. She didn’t give up on him and her persistence led to a good outcome in the end. These two contradictory feelings left me questioning what was real. However, paradoxical feelings seem to capture the complexity and contradictory thoughts that this kind of work gives rise to, and also give clues to the nature of the underlying psychic dynamics.

The interview with Cheryl was unusual in that she romps through the disturbing facts about Lee’s early accommodation very quickly at the beginning of the interview, hardly stopping for breath. Although she describes pretty horrifying events, there is no real sense of her emotional connection with the content of what we are talking about. The significance of what is being described and the underlying psychic pain is heavily defended against. Instead we laugh together in disbelief at what we are talking about. Similarly to the experience with Maude when she described her partners deaths. This disconnected, manic and emotionally obliterated quality was discovered during clinical supervision. Another thought was that the professionals were mirroring the mindlessness of the mother on drugs.

However, there is a moment towards the middle of the interview when the quality of our emotional engagement with the subject matter changes and we become much more connected up with the pain and tragedy of events. I remember that I felt tearful and moved with what the social worker was saying, particularly when she described Lee as being scared at his mum’s funeral and when she described Maude being frail and childlike before her death. Maude had disappeared after the care proceedings and the news that she was going to die came out of the blue to the social worker. Here is Cheryl describing her attempt to work with Lee in order to prepare him for his mother’s death. She has discovered that Maude has moved into a hospice and arranges for Lee to visit with the foster carer:

Cheryl: I went on one, because she managed to say on a Friday that she could see him, so I went on the Friday one with her and the foster carer, that one went really well, that was a good day for Maude, so she managed to get in the wheelchair and we managed to walk in the little garden area and he just wasn’t that worried, we did say mummy’s ill and that is why we are going to visit mummy (yeah) erm, but we didn’t say yet that mummy was dying we said mummy’s ill and because I wanted him to see that his mum is

ill and erm, rather than, because he hadn't seen her for a while and I just couldn't bear telling this little boy that his mum had died and because she was ill and he would say well I haven't seen her ill, erm, (pause) she promised him on that visit that she would buy him a playstation and when she gets out they would go to the park and so we were just, kind of like normal to you know, making the plans but also you know, unrealistic and we had to help her say you know you can't just make promises you know, you won't be able to keep them so then he went, like I said everyday and erm, the foster carers took him over the weekend, so they took him on the Saturday and the Sunday and she passed away on the Monday morning, so um, yeah

Anna: God that's so sad isn't it

Cheryl: That was really sad so I had to go and pick up the memory box and his bag but she was all alone, she was really ill, but also tiny like a child because I remember her being that tall blond woman (yeah) and just tiny like a child, she was like, so tiny, when she was going. That was brought on by, because we believed that her illness was brought on by the overdose of her son, because her oldest boy, who was his brother, had an overdose in June, a month before Maude died (yeah) (Interview with social worker).

This extract also raises the question about what it is like for social workers who go into the profession to help people, when their clients get worse and even die. We see in Case J (Lola) the consequences of this dynamic on the internal world of the social worker who appears traumatised and paralysed. In this extract Cheryl seems to be compelled to talk about the experience, which perhaps no amount of training can prepare a social worker for.

From Defensiveness to Connection

The descriptions of what happens to Lee by the social worker in the latter part of the interview becomes quite insightful and attuned, far from the disconnection of the social worker at the beginning of the interview. Perhaps the interview has also provided a reflective space for the social worker where she is able to connect up with the emotional significance of what she describes. Therefore the interview provides containment, which she is then able to use.

Thoughts About Drift and Delay

Lee is one of the most deprived children I have worked with. He experienced an appalling level of neglect, suffering and pain, both prior to being accommodated, and then while being in care. The seriousness of his life circumstances contrasts sharply with his age and capacity to understand what is happening to him. However, it appears that the social worker, who seems to suffer alongside him or on his behalf, is able to provide him with an experience of containment, where his needs are thought about, in this way offering a different outcome to that of his mother, following her own childhood

losses. What comes across in the interview is how identified Cheryl is emotionally with the ups and downs of Lee's life, at times she even presents as a deprived child herself (This particularly comes through in the interview when she describes how no one was willing to drive Lee and her to his father's funeral). Cheryl has become identified with the child's pain and deprivation, a dynamic Rustin (2005) warns about. It is very likely that I have also identified with Lee's pain, due to my own circumstances around losses (My own mother, father and brother died around the same time and in similar circumstances, involving addiction, overdoses and sudden illnesses). The level of Lee's deprivation and the consequence strength of his projections overwhelms the social worker and leaves her struggling to find the attention to progress permanency plans. She is also so involved in the minutiae of the unravelling of Lee's experiences, that she is unable of taking in the bigger picture i.e. a long-term view. Despite this and with the help of a thoughtful organisational system (the adoption panel) Lee is eventually provided with the care he needs. There is a sense of belonging, tolerance and acceptance by his new family.

My best thoughts about delay for Lee are that there was a terrible paralysis in the system caused by a number of complex factors, particularly issues relating to the deprivation of the child and dissociation in the mother. It is as if 'permanency' has to be placed to one side while Lee deals with the successive losses in his family. The social worker necessarily turns towards helping him with the consequences of these losses rather than take a longer view about his care plan. Therefore, linking to Case J, which highlights the deprivation of the parents as a central factor in decision making, in this case it is the urgency of the deprivation in the child that overwhelms the worker and the system's capacity to make decisions about permanency. It is not until the losses are experienced and dealt with, that Lee can be 'freed for adoption'. Similar to the dynamic in Case J, when the social worker is unable to keep two complex needs in mind (parent and child), Cheryl is unable to keep two processes in mind, how to make the losses for Lee as understandable as possible for him, while thinking about his long term needs. His short-term needs are hugely pressing and urgent and there is literally no time or space to think about care planning.

It may also be interesting in this case to examine whether Beckett's (2010) thoughts about delay causing psychological harm, can best explain what is occurring. Or alternatively as Cooper and Webb (1999) argue, whether Lee's impermanence is somehow related to his own state of mind and is a post-modern dilemma. It does appear that it is the child's deprivation and the behaviour arising out of his traumatic experiences that stuns the attention for the care plan and makes permanency secondary to meeting his immediate need in relation to his losses. There is some evidence in the interview that caring for Lee is difficult for his foster carers due to his aggression and

destructive behaviour. However, as Ward et al (2006) argue it also appears that the system replicates this state of mind, by providing emergency foster carers, respite carers, who provide neglectful, inadequate care, and which results in him moving from crisis situation to crisis situation. This clearly illustrates Cooper and Webb's description of systems replicating the child's state of mind, mirroring externally what is experienced internally. It is not until Lee's case reaches the adoption panel, four years into his accommodation that the parties involved are able to think in more depth about Lee's emotional needs. The adoption panel offers a structured form of containment and thinking space for the social worker and Lee's care plan gets back on track and he finally moves to prospective permanent carers in a planned way.

Case A: Borderline Dynamics

"In early schizoid processes and borderline syndromes, the 'border' is not only between the paranoid-schizoid and the depressive positions, but also between the various states of part-objects and part spaces and domains to which they belong in the course of development and in terms of hierarchical organisation. 'Borderline' means the absence of communication between those dynamic structures which go on functioning separately and are incapable of integrating." (Rey, 1994)

In this case I try to capture the maddening effects of trying to make a definitive decision about a child when the parent, convinced of the rightness of their argument, brings to bear pressure on the social worker to think in one way, then changes their of mind at the last minute, pushing the social worker the other. This ambivalence towards her child gets acted out by the system where a decision remains in a borderline liminal state. The case study captures the internal state of the borderline state of mind, which finds no easy intimacy in relationships, either finding them suffocatingly close or terrifyingly distant.

Case A involved a 6-month-old White UK boy of Greek Cypriot heritage called 'Christopher' who was in short-term foster care at the beginning of the assessment. He was 6 months old at the start of the assessment. He was approximately 13 months before care proceedings began. Proceedings lasted over a year and therefore he would have been approximately 2 years old before an adoption order was sought (and close to 3 years old by the time adoption went through). Christopher was the second child of 'Antonia,' a 22-year-old woman of Greek Cypriot heritage. Antonia was separated from Christopher's father (White UK) at the time of the assessment and he was not actively involved in his son's care at that point. He was not part of the assessment, as the local authority had spoken to him and he told them he did not wish to care for his son.

The parenting assessment was of Antonia's care of Christopher with a view to his rehabilitation home. I was asked to comment and make recommendations about the support Antonia needed in order to assist rehabilitation. There was contact between Antonia and Christopher on a daily basis, occurring in the home for a few hours at a time. This was supported by contact supervisors who picked him up and dropped him off, but the contact itself was unsupervised. The social worker was very supportive of the plan to rehabilitate the child home and there were no questions raised at the beginning of my assessment whether this was the best care plan or not.

Antonia's background

Antonia had a complicated, strained relationship with her parents. Her parents lived abroad for most of the year but were due to return home towards the end of the assessment. Antonia was living in their house with her sister and as their arrival became imminent, her memories of abuse by her father resurfaced and had an impact on her decision making for Christopher. For example, she felt protective of him and did not want him to be abused by her father, as she had been abused. This was one of the original reasons she had for wanting Christopher to be adopted.

I undertook a Genogram with Antonia and she described a rather complicated family tree. Her father had been married for about 8 years prior to his marriage with her mother and this ended due to infidelity. He had two children with his previous wife, therefore Antonia had two half brothers. However, they had died of organ failure aged 8 and 5 years old. This was apparently related to the same blood condition that she currently suffered from.

During the parenting assessment Antonia had vivid memories of domestic violence between her parents. She also remembered being shouted at and humiliated by her father when growing up:

Antonia was very uncomfortable providing details of her father's history as she was very concerned that he may find out she had been talking about him and either G (birth father) or her father would read the report. I reassured Antonia that this would not be the case and while she told me about her fears she seemed to vividly remember an abusive scene from her childhood where her father placed a label with her address on it on her forehead in response to her revealing to her teachers that she had moved home. Antonia began crying, saying that her father had become really angry with her. She still felt powerless when faced with her father's anger; she never argued with him but he argued with her and she thought the social worker may be able to protect her from him now. Antonia explained about the family meeting that had been planned and she was still worried that her father would explode [...] I gained the strong impression that Antonia continued to experience the traumatic effect of her father's abuse, as if she were a young child and would

find it difficult to protect her self emotionally from his influence. (Parenting assessment dated 26,11,07)

During the parenting assessment Antonia remembered her mother as a depressed woman when she was growing up, often crying and she describes her as 'loving but distant':

Antonia said she was born in [name of Hospital] and her mother had a threatened miscarriage with her. She thinks her mother was depressed as she was growing up, as she hardly spoke, locking her self away and never played with them. She was never happy or jokey and saw her crying at times. (Parenting assessment dated 26,11,07)

Her parent's had a 'crazy' relationship full of violence, which she remembers from about the age of 4 or 5. Her father would take the fuses out of the plugs so that her mother could not watch TV but her mother would sneak them on again. (Parenting assessment dated 26,11,07.) Antonia described it being better when her father was at work.

Antonia was living with her sister at the time of the parenting assessment. She told me that she didn't like her sister and couldn't wait until she moved out. However, during another home visit she said she was her closest support. (Parenting assessment dated 26,11,07)

Relationships and the Dynamics of Rejection

Throughout the assessment Antonia was very certain about expressing her wish to have Christopher return to her care. She placed huge pressure on professionals who she thought we were conspiring to keep them apart. Plans to return Christopher home were too slow and deliberately so, in her mind, with a quality of withholding. However, towards the end of the assessment, just as he was about to be returned home, she began expressing doubt, feeling that things were happening too quickly and that she needed more time, even up to a further year so that she could receive more therapy. She also informed me in one of our final meetings that she had recently experienced a psychotic episode but had not told anyone about it.

There were a number of confusing and complicated changes of mind impacting on the social worker's ability to form a judgement about what should happen to the child. When she was pregnant Antonia wanted Christopher adopted. Then, when she gave birth to him she changed her mind and wanted him to live with her. After 3 weeks in her care she changed her mind again and wanted him accommodated as she was struggling to cope. Then, when he was in care she wanted him home again and felt that he was being kept from her. Despite a dedicated attempt and plan to rehabilitate him home she

changed her mind again and became very anxious about whether she would cope. Therefore, the *desire* to have Christopher with her and the *reality* of Christopher were mismatched and highly contradictory. This push and pull reminds us of Rey's (1994) description of a claustrophobic reaction to intimacy, where problems of closeness and distance become impossibly irreconcilable (Reminding us of the phrase 'can't live with and can't live without').

After my involvement in the case ended, I heard that Antonia wanted Christopher home again saying she had made the changes necessary for him to be returned to her care. She accepted all of the evidence in my report but argued that she had managed to address the problems that the report raised and that she was able to care for Christopher once again.

When Antonia wanted Christopher home she sounded very convincing about her decision and this influenced my, and the social worker's views about the case - both working towards rehabilitation home under some pressure to agree with the plan. Here is an extract from the interview with the social worker capturing this dynamic:

*Nadia: She explained that she had changed her mind about adoption in July and knew for certain that she wanted him home, as soon as possible.
(Interview with social worker)*

Despite her assertions of wanting him home, in reality I observed that Antonia had a very poor grasp of how to provide for Christopher's basic physical or emotional needs. This resulted in a difficult feeding relationship and a sense of tension and panic during contacts. Antonia was very sensitive to feeling rejected by her baby and became upset if Christopher would not eat the food she offered to him immediately, getting hurt and frustrated if he turned away from the spoon. Feeding was painful to watch and fraught with emotional turmoil and anxiety.

During my assessment I thought that I noted a pattern whereby Antonia rejected Christopher when she felt rejected herself. For example, the first request to have Christopher adopted occurred during her pregnancy when she spilt up with her partner, Christopher's birth father. During the assessment she informed me that she felt very rejected by him. Towards the end of the assessment Antonia said she felt rejected by her therapist. She thought her therapist had just told her that they were leaving but the social worker describes how a rather benign conversation with her therapist was misinterpreted by Antonia. The social worker explains this during the interview:

Nadia: The counsellor said we need to talk about what your counselling needs are in the future and she had taken that as a rejection. (Interview with Social Worker)

During the interview the social worker highlights the patterns around the mother's feelings of rejection:

Nadia: ...and I think that that was reflected in the contact, if Christopher went away with foster carers for example, or if Antonia was ill and we had to pause the contact or even if there was no immediate recognition of mum, he was distracted by a toy, it was really age appropriate, there was a really shiny toy in the corner, she would see that as a rejection. (Interview with Social Worker)

Antonia and the baby's father had an 'on-off' relationship. She told me that they had a 'trust issue' between them and they ended up continually arguing. (*Parenting assessment dated 26,11,07*) They were not in a relationship at the time of my assessment, however, they were 'back on' shortly afterwards. Suddenly their romance ended again and Antonia informed professionals that she was moving in with a new boyfriend. She brought this new boyfriend unexpectedly to a meeting in which we had to discuss the recommendations I was making in my report. It was incongruous to have a stranger invited to such an important and potentially difficult meeting.

I had a relatively good relationship with Antonia throughout most of the assessment. However, this seemed to deteriorate towards the end and she became more impatient and distrustful towards me, questioning my independence then apologising for being paranoid. This also coincided with my own developing doubts about her ability to care for Christopher. Antonia became suspicious of professionals and their motives in general, doubting that she could trust anyone. She seemed to close down to support, seeing those she had previously seen as benign figures, now as bad figures wanting Christopher to remain in care for their own financial gain (such as the foster carer).

Antonia immediately took me into her confidence at the start of the assessment complaining about the other professionals and the foster carer. When we had a professionals meeting at the end of the assessment we realised that she had complained about each person to the other, resulting in a high level of suspicion and distrust between professionals. This particularly upset the foster carer who had provided her with a lot of support and who thought she had a good relationship with Antonia. Antonia complained that the social worker and foster carer wanted to keep her son from her and said that she wanted her son returned home as quickly as possible so that she could,

...get everyone out of her life and leave her alone. (Parenting assessment dated 26,11,07)

I had a good relationship with the Social Worker even though we had a difference of opinion. She was heavily invested in the idea of the child being returned home, believing that children should be with their parents wherever possible. It was her first adoption/court case. The social worker was able to change her mind following my assessment.

Countertransference

I remember the feeling of being out on a limb when writing up the parenting assessment, as I had been brought into the case with a view to provide advice on the support the mother would need *when* the child was returned home. Rehabilitation was the only care plan in mind and therefore I felt I was stepping out of my agreed remit by making recommendations about no rehabilitation and advising adoption. It felt like there was a huge push to get the baby home by the social worker. The social worker was so certain that this was the best plan that the other professionals expressed relief when I made the recommendation for adoption. They said they had not raised concerns with the social worker before, because they did not think they would be listened to. Doubt and uncertainty were evacuated from awareness until the last moment, reflecting the mothers state of mind.

The strong pattern of push and pull and the impact that this would have on Christopher emotionally, convinced me that it was in his best interests to be adopted outside of the family. I linked this oscillating feeling towards her baby to the mother's own feelings of rejection, which left her vulnerable to rejecting the baby. This understanding of a deeper unconscious pattern alongside observing a very painful relationship between the mother and baby manifesting itself in the feeding relationship, allowed me to make quite a bold assessment, flying in the face of current thinking about what should happen.

Causes of Delay

There were a number of episodes when the decision for the child was delayed. It was initially delayed because the mother could not make up her mind whether she wanted the baby or not. Then there was further delay as rehabilitation home appeared to be in the best interests of the child and there was huge pressure from the mother for the baby to be returned home, which the social worker agreed with. This was managed through a voluntary arrangement of care for the child under Section 20 CA 1989. Then the social worker describes being very indecisive for 5 months after receiving my report, which recommended no rehabilitation home. Once the situation deteriorated with Antonia a decision was made to proceed to court.

During the interview the social worker explained that the court process was quite lengthy. It was over a year in proceedings. The adoption order had still not been made when I interviewed the social worker at the end of this time. The social worker explained

that the cause of the delay was initially because the Guardian advised the judge that a new parenting assessment should be undertaken, focussing on the older child who was living at home. The assessment was to include the mother's parenting of this older child and the impact the plans for Christopher would have on her. The social worker also explained that they had to commission further psychological and psychiatric assessments of mum, even though her consulting psychiatrist had already made a definitive statement regarding her mental health issues in relation to the child's needs.

The social worker also said that some of the delay was due to a new set of legal procedures (the 'PLO' New Public Law Outline)-and that this was the first time the Local Authority had filed for Care Proceedings under the new procedures. Therefore, they were 'between two systems'. She explained that under the PLO there needed to be proof that you had given the parent every opportunity to change. This usually translates to formal procedures such as written agreements, timescales, formal legal letters, legal planning meetings, etc. Assessments are supposed to be undertaken prior to care proceedings.

The social worker explained that there was also delay because of the assessment of potential kinship carers who came forward and then pulled out. Strikingly, there was further delay because the foster carers put themselves forward at the last moment, only to then change their minds. Their change of mind was 'very very late' in the proceedings (interview with the social worker). The social worker links the delay and change of mind to the relationship between the carers and mum:

Nadia: well on top of that mum she was quite hopeful that the foster carer (ok) would pursue adoption and erm, I mean the network had concerns about that anyway because erm, in some way had formed, some form of reliant relationship (ok) on the foster carer; that was both at times very positive, and I think you brought it up in your assessment, at times there was a lot of em, you know internal resentment as well (yeah) erm, but at the same time the network felt that mum might have been clinging on to the foster carer possibly adopting Christopher because she would be hopeful but then she could maintain links and I think that was also another reason that the foster carers in the end reconsidered because they were concerned about that relationship and how it could be managed. (Interview with social worker)

This example beautifully captures a sense of history repeating itself, with the dynamic of the mother's ambivalence being mirrored or re-enacted by the foster carers. The social worker is describing how professionals thought that the foster carers had become enmeshed with the mother. The late recognition by the foster carers of this situation leads to them withdrawing their offer of long term care for the baby. Therefore the baby is rejected by the foster carers in a similar way to how the mother rejects him, as if they have also become identified with Antonia's state of mind. This also raises the question

about whether Antonia was able to make professionals and carers feel guilty, eliciting an overly placatory response, until this made them feel uneasy and worried about managing the dynamic. Thus problems with managing closeness and intimacy become played out in the care plan. The social worker agrees with the dynamic I described as ambivalence:

Nadia: I think that feeling continued throughout, so even though mum was consistent in the fact that she was contesting there was still in so many different ways she showed level of ambivalence and contradictory feelings really about Christopher returning to her care. (Interview with social worker).

Nadia describes the emotional impact the work had on her and her ability to make decisions:

Nadia: partly because mum takes you on that roller coaster - her feelings change, her views change, it was difficult to keep up with her emotional responses, ...the parents place you into that chaos, and getting that clarity was difficult

Anna: Making a decision and sticking with it was difficult

Nadia: There are some cases when it is so clear that this is in child's best interests, but in some cases where the parent has stabilised... it is difficult making a decision about long term effects the decisions will have on the child. (Interview with social worker)

Borderline Dynamics

There was significant splitting in this case, a dynamic to be expected in cases where schizoid states of mind and borderline dynamics occur. In splitting, people are usually viewed as either all good or all bad, idealised or denigrated. For example, Antonia was solicitous towards each professional making them feel that they were important, showing her vulnerability to them. By being familiar with them, and asking for their support she made them feel that they were in a special relationship with her and had a privileged understanding of her needs. They were the good, understanding professionals. To these privileged professionals she would complain about and denigrate another professional, thus splitting professionals into good or bad. Then she would criticise the same worker to the next professional behind their back. This would raise questions and suspicions between professionals about each other's capacities. This was particularly the case with the foster carer who felt betrayed when she found out that the mother was suspicious of her motivations to care for Christopher. It could be argued that the foster carer should have been protected by the organisation from having such a close relationship with the mother. In the end this relationship had a significant negative impact on Christopher's

care plan, as the carers place themselves forward to care for him, only to withdraw due to fears about boundaries with the mother, causing further delay and confusion.

Another example of the dynamics of splitting is the way professionals did not communicate with each other until the very end of the parenting assessment when I called a network meeting. At that meeting the contact supervisors told me that they believed the social worker would not listen to their observations or concerns, as she was convinced the baby should return home. The contact supervisors said that they were relieved that my observations of Antonia's parenting confirmed their own thinking, as if their own perceptions of reality were in question. This discussion occurred before the social worker arrived at the meeting and I was left feeling that the social worker had a closed mind and fixed policy about the care plan for the child and was unable to listen to concerns. During the interview the social worker criticises the contact supervisors, indicating poor working relationships and a lack of trust between professionals. This dynamics seems to mirror the one between the mother and professionals where each is suspicious of the other and set against each other.

The main splitting however, occurred in the mind of the mother, which the social worker appears to identify with. For example, Antonia is convinced and convincing that the baby should return home. She pushes all doubt about her capacities aside and seems to forget that she has asked for Christopher's removal on two previous occasions. The social worker describes her as making improvements and was convinced that the baby should return home. It takes 5 further months of difficulties and delay for the child following my assessment, before the social worker can change her mind. However, in contrast to the social worker's view and from close observation I quickly discovered that there were fundamental problems with Antonia's ability to meet Christopher's basic needs. This was particularly exhibited in the feeding relationship which is fraught with anxiety, disappointment and disconnection.

This dynamic reminds us of Angela Foster's (2013) poignant realisation that professionals tend to collude with the healthy, idealised part of the person, leaving the disturbance split off from awareness, unthought about and therefore untreated. The woman she describes in her paper goes on to commit suicide in part due to their willingness to collude with a projection of a healthy side of her personality. Linked to this idea, when I begin to address the mother's disturbance with her she actually begins to open up to me and is able to tell me about a recent psychotic episode she had. The facade of coping and being ready to look after the baby quickly falls away and I believe there is some relief by the mother who the social worker says does not contest my evidence.

This splitting may function as some kind of desperate attempt by the mother to control her mind through projection, originating from a fear of disintegration. In this case the baby is not a separate person with his own needs or experiences, but acts as an extension of herself, functioning as a receptacle for her to project feelings of longing and rejection into. The baby's threatened adoption means a loss of the projected parts of herself. There was a complicated and claustrophobic feel to the relationships. We are reminded of Rey's (1994) observations about problems in intimacy in borderline dynamics. Rey describes the borderline state as falling neither within neurosis or the psychosis, however, psychosis can occur in the borderline state of mind. He describes borderline states as originating in problems with intimacy which has a time and spatial element, resulting in problems of negotiating distance and closeness with others.

In this case we can see two extremes of thinking, and shifts in state of mind being played out with the baby. Antonia comes across as trying to be either very close to the people around her or very distant and hostile, with no in between. This occurred with her baby, partner, sister, professionals and must have replicated a model of relationship handed down from her parents. Rey (1994) terms the relationship between internal objects in the borderline state as 'claustro-agoraphobia,' where the person is unable to cope with either closeness or separation. Rey links these difficult states of mind with a failure in early maternal care. This failure leads to a feeling of closeness being too overwhelming but paradoxically separation is also feared. Therefore there is no feeling of security or being at ease in intimate relationships. This results in Antonia feeling she wants the baby but a feeling of panic when the baby is going to be returned.

Although I have presented the above information in terms of psychoanalytic interpretation, there are other informative interpretations, sociological or systemic. For example, Antonia and her family exist within structures, which marginalise women with mental health problems, leaving them isolated and lonely. Her desperate attempt to seek closeness with professionals may have been in response to this feeling of loneliness and an awareness of her powerless position. From a systemic point of view, the system may have become closed down, without the necessary skills to open up dialogue and develop something new and more hopeful. I am also always aware that I may consider situations as more hopeless than others and the hopefulness of the social worker and commitment towards Christopher's return home is a more preferable position to start from, rather than a pessimistic view. However, I recall being quite convinced about rehabilitation for Christopher at the beginning of the assessment, only starting to doubt this from direct observations and meetings with Antonia. The starting point was an open mind.

Further Reasons for Drift and Delay and Guilt

I offer a further tentative reason for delay in decision making. It is suspected that unacknowledged feelings of guilt in the social worker may have interfered with the decision making about the case. Little bits of evidence indicate that guilt played a part in the unconscious dynamics affecting the social worker's decision making. For example, at the beginning of the assessment I noted that Antonia was getting a huge amount of support from the social worker, with 5 days a week unsupervised contact in her home, and a comprehensive level of contact with the foster carer between those times. The social worker feels strongly that the baby should return home:

Nadia: ...in terms of Christopher - I have really wanted her to manage it — at times she showed very positive signs she could manage it but when it became obvious she couldn't yes, this is outcome, but I would have wanted to see her look after him. (Interview with social worker).

It is possible that the guilt Antonia could not feel about her ambivalence towards Christopher was projected into the worker who, through projective identification, identified with the feelings, making her determined that the baby should return home, despite there being evidence that the mother was highly ambivalent about her child. Guilt is raised as a problematic factor in social workers decisions by writers such as Woodhouse and Pengelly (1999), Bower (during clinical supervision) and Beckett (2014). As discussed previously, guilt is a developmental achievement and for those who have experienced failure in early maternal care, concern for others and an ability to reflect on one's impact on others or make reparation can be compromised. It is highlighted as a particular difficulty for those with borderline states of mind. Therefore guilt is more likely to be split off and projected into the professionals in order to be rid of uncomfortable feelings. Thus misplaced feelings of guilt can become avenues for distorted judgement in social work decisions. I have experienced feeling crippled by guilt during my work, making me doubt my assessment and consider supporting unsatisfactory and often abusive situations for children, as a way of avoiding causing more pain to the parent. This is why independent clinical supervision has been so vital in making good decisions, it provides a methods of analysing feelings of guilt and introducing a proper perspective. Realising that guilt belongs in the parent and understanding the nature of projections, affords huge relief and makes for clearer judgement. This is an area of enquiry which need to be explored through research in the future.

5. Discussion of Findings

In this chapter I discuss the main findings from the research in relation to the research questions. In Part One of the research, ‘stuck cases’ and ‘intergenerational abuse’ developed as prominent themes. I explored these themes when analysing the interview data in order to see what could be revealed about why cases became stuck. ‘Intergenerational abuse and neglect’ inevitably resulted in emotional deprivation in the parent which in turn affected the parent’s care for their children. I looked at these themes and how the underlying unconscious dynamics related to deprivation and abuse may have affected decision making.

This examination not only gave me insight into why the cases became stuck, but it also helped me to develop ideas about what facilitated the progression of cases. In particular, I was able to determine what effect the parenting assessment had on the social worker’s views and the Care Plan for the child. For example, whether the parenting assessment changed their mind, confirmed their thinking, or whether it was considered but ultimately dismissed.

Stuck Cases

What was striking about all of the cases was that the care plans or social work involvement had become ‘stuck.’ There was a high number of children who had been known to social services for severe concerns over many years (26 out of the 31 children = 84%). I believe that this area of work, the borderland where decisions about children being removed from their birth parents, is one of the most stressful and anxiety provoking areas of children and families work. Psychologically it is one of the most difficult decisions that social workers have to make and in this study some of the most difficult of decisions are often undertaken by inexperienced social workers new to the work. These social workers are often poorly managed or lack the guidance and containment this complex work demands. The emotional impact of the work goes largely unrecognised, the level of difficulty is downplayed. Given what we know about what the work entails (Case J) it is no wonder decisions get put off as decisions about permanency mean removing children from their parents and feeling of futility when it starts all over again with a new pregnancy.

This ‘stuck’ quality must have been one of the reasons senior managers eventually decided to refer the case for a parenting assessment. It became clear when undertaking the assessments that children had been suffering significant harm for long periods of time and these concerns were known about by the organisation. It is hard not to interpret the inadequate response as ‘turning a blind eye’ to the children’s suffering, indicating

that the organisation had become heavily defended in some way, and often unable to focus on the child's needs. These 'stuck' cases were particularly complex, demanding a high degree of emotional involvement and processing to understand and resolve during the assessment process. It was expected that the assessment would process high levels of information from various sources, to become involved in fractious and tense (even dangerous) family environments, interpreting conflicting views from the social workers, managers and other organisations, to make the most difficult of recommendations that often led to the permanent removal of the child from their parent's care. This is one of the most anxiety provoking areas of work in child protection and perhaps another reason these recommendations were outsourced to me. The 'rubbish bin' feeling Woodhouse and Pengelly (1991) raise in their study is displaced into someone else.

The Triangulating Effect of the Parenting Assessments and Impact on Decision Making

What became increasingly clear in the course of the interviews was that very often the social workers changed their minds about returning children home to parents after they receive the detailed report from me, recommending alternative permanent care instead. The reports provided strong evidence about the harm the child had suffered, or was likely to suffer in the care of their parents. The reports contain information about all of the family members including the parents and their histories. However, the reports are particularly strong in focussing on the child, due to their observational stance. They were effectively bringing the child back into mind, where they had become 'lost'. From the discussions with social workers, there are a number of cases where my input was clearly instrumental in the social worker's change of mind, or the local authority's change of care plan. The care plan becomes about seeking permanency outside of the immediate birth family, either through adoption or kinship care (Cases A, D, F, I, J, K, M, P, O = 15 children).

The idea developed during *clinical supervision* with my supervisor Marion Bower (Nov 2014) was that the parenting assessment itself formed a triangulation process and provided information leading to a reflection upon the child's needs. This triangulation offered an alternative perspective and a containing space, which enabled a move from identification or preoccupation with the parent's needs, to a position where the social worker could identify with the child's needs.

I present a series of 3 diagrams (Diagram 3, 4 and 5) to represent the process of identification and the triangulating effects of the parenting assessments. In the first diagram the social workers has lost sight of the child and is facing towards the parent, before the parenting assessment occurs:

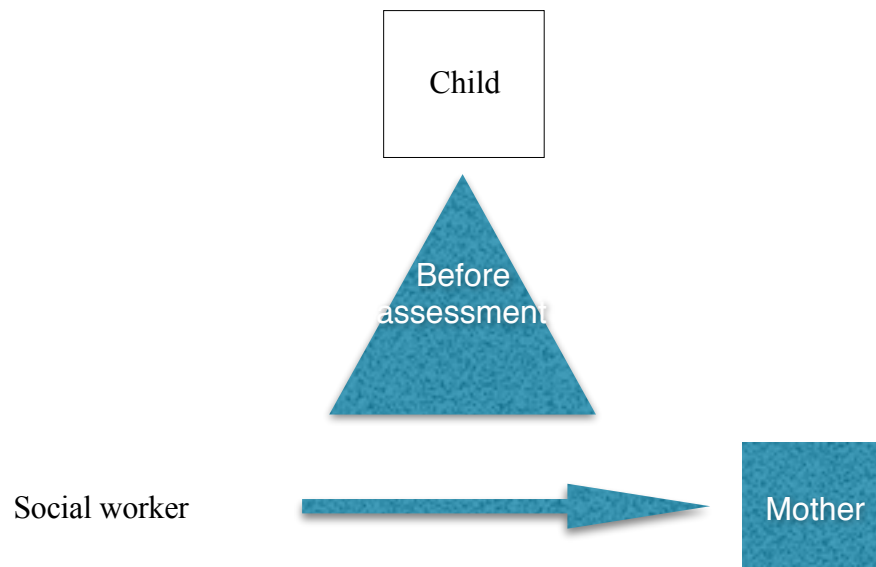


DIAGRAM 3: SOCIAL WORKER OVERWHELMED/IDENTIFIED WITH PARENTS NEEDS

In Case A, the parenting assessment definitely facilitated a shift in the social workers thinking, as she initially wanted to return the child home:

***SW:** well we did initiate care proceedings and erm, since, now Christopher is with prospective adopters as we gained a full care order and a placement order (ok, ok) erm, in respect to Christopher and we are hopeful to gain an adoption order (Interview with social worker).*

Following my evidence and some difficulties in the case, she describes a shift in favour of a plan for adoption. She describes this as a difficult process, but once this decision was made, she was convinced it was in the best interests of the child. As in Case J the mothers difficult behaviour helps along the recognition of a need for a change in the care plan. Excerpts from the interview, show the social worker immediately confirming the outcome for the child once my report was received:

Yes, so it definitely escalated and spiralled in the December and really that coupled with your assessment, really made us initiate the proceedings... Mum wasn't denying your assessment. She said that she had made changes. Your assessment was quite clear about why you made the recommendations. However, in the first 5 months it was really difficult to convince ourselves about what the strategy was, but once it hit December we just did, it was so clear. The evidence was there. It was difficult to make decisions, but once made, we didn't doubt it. Although mum did make improvements. (Interview with social worker)

In Case J it was significant that although her managers told me the social worker wanted to return the child home at the start of the assessment, her opening statements during the interview were in fact in complete accord with my recommendations for adoption. This was an unexpected shift in the social workers position and was a surprise for me. She states quite bluntly that the court ordered that the child should be placed for adoption and:

*...it was inevitable that we should get this care order and placement order.
(Interview with social worker)*

She states that the 'evidence' (meaning my assessment) was 'quite conclusive' and she even spelt out the grave risks if the child were to be returned home, perhaps even amplifying them by stating:

Well it felt quite satisfying because obviously the concern was that if A had stayed at home, she may have been, she may have died because the risk to her was very huge, or she could have been injured or she was clearly at risk and that was something that the local authority did not want. (Interview with social worker)

These opening statements surprised me as I thought Mina was still ambivalent about the recommendations and outcomes. We did not have a straightforward relationship, I felt some distance from Mina during the assessment. Mina was probably not too grateful about having to make the shift in her thinking, but she appears accepted it.

As in Case J, the social worker here immediately confirms that the parenting assessment precipitated action to secure Lee's permanent removal by beginning care proceedings:

...urm, er, we went in for care proceedings.....oh, yeah, yeah, we wanted to know from, whether mum would be, and then we could go in for care proceedings...(Interview with social worker)

In Case P the male social worker again quickly informed me that my assessment about rehabilitation, to the children's mother was followed:

*Well, with Benjamin - starting with the care plan - the care plan was no rehabilitation to mother. Mother was ruled out because mother did not follow your assessment, even attend assessment as you rightly point out.
(Interview with social worker)*

There seems to be little in the cases to indicate that other outcomes were available with respect the mother. However, with the addition of my assessments of the fathers, the

social worker is a little more ambivalent and reluctant to follow my recommendations, indicating that he had been considering rehabilitation to their care. Therefore, my assessment provided triangulation and had some influence in changing his mind, although it was finally the reluctance of the children to even meet their father that changed his mind about rehabilitation to the father's care.

Diagram 4 shows the shift from an identification with the parent and their needs towards a refocusing on the child through the triangulating effect of the parenting assessment:

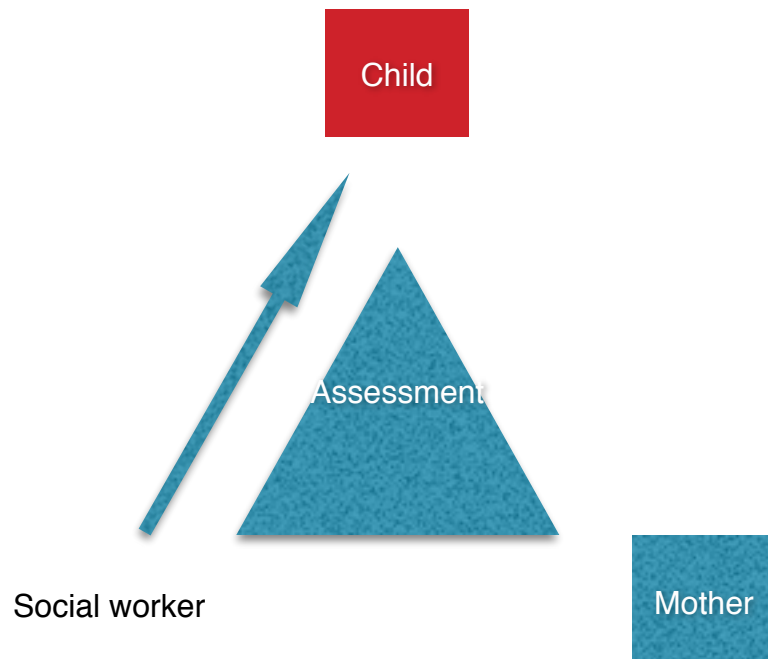


DIAGRAM 4: KEEPING THE CHILD IN MIND

Triangulation doesn't have to be about changing the worker's mind but can be about confirming their views and giving confidence. As in cases F, H, I, K where the social workers seem to be able to have a confidence in their own thought processes and decision making.

Keeping the Child in Mind and Progressing Good Care Plans

In some of the interviews I was struck with, just how present or absent the child was in the social worker's account, and how connected or disconnected the worker had become with the reality of the child's emotional experiences. For example, in Case J the social worker rarely mentions the child and never spontaneously talks about her. Any mention of the child has to be elicited quite strongly, and she is talked about in very few words compared to the overall length of the interview. The interview is mainly taken up with a concern about the parents needs and the difficulty of the work. I will describe this in depth in Chapter 5, the interview material is rich in bringing these issues to light. Similarly in Case A, the social worker is much more engaged in the mother's wishes

and views and concerned with her needs as a very vulnerable women, rather than with those of the child. The child is rarely mentioned and really doesn't come alive in the social workers mind in his own right. In Case K, superficially the social worker appears to be very concerned about the child, however, from a closer reading of the interview transcript it is clear that at the beginning of the interview she is disconnected emotionally from the reality of the child's experiences. The emotionality of the content is obliterated, possibly mirroring the mother's state of mind i.e. obliterated by drugs. Again this dynamic will be described in greater depth in Chapter 5.

Case P reflects a more mixed picture, as the social worker has met and become familiar with the oldest boy, Benjamin but not with his younger 4 siblings and as a result there is a stark contrast between his interest and emotional investment in the oldest boy's care plan. We really get a sense of who Benjamin is with his likes and dislikes, wishes and feelings. We also get a clear impression that the social worker has met and engaged with him, taking his views seriously. He is obviously influenced by the boy's wishes and feelings and the interview is quite moving and poignant at times when the social worker describes how Benjamin wants to be looked after by his cousins who are only children themselves:

Osiris: ...Well in the first instance not so much with Benjamin but with most children we take into care they want to go back to their first carer, the one we took them from, who abused them so his first preference was to live back with his mother...and if he could not go back to live with his mother he wanted to live with his em, cousins who were the same age group and we say that is not really possible and then em, we just said ok cos through the care proceedings he was always kept informed of the local authority's care plan where we said in terms of family members, if your parents can't look after you but given the circumstances if any of the parents can't look after you too, there are no other family members come forward and that leaves us with the third option which is to be in long term foster placement and ??? we always ask his foster carer first then we ask him...we spoke to him alone and said the choices you have, the only choice you have actually, because your parents are ruled out, because there are no family members coming, and those the cousin you said are too young, they're not going to care for you because (laugh) they are children as well and that's not possible. The only option is long term fostering, we will consider your present carers and we will look at for other carers so what would you prefer, so he said well if he can not go back to his mum and no family member, he would like to remain where he is, he doesn't want to move, so that is ok, that is fine, we will explore that further, that was explored further, so that is why today he is with his foster carers, he is settled and doing well (good) at that short term placement, it's not long term placement

Anna: And does he still continue with his football?

Osiris: *Who well that is all about his life, football, football, (laughing together) and he is lucky the carer is able to meet those needs to keep his football (supportive) and he is playing a couple of matches, and he has joined a local football club which he plays for, so he is doing well in terms of that. Educationally he's doing well too, there is no trouble from school given the background (yep) he came from and how destructive he was when he came into care (yeah, yeah) there is a kind really, dramatic change and 100% turn around (wow) because his compliance? has gone up 100%, there's no complaint from school, like at his PEP meetings if the school say if we were not told he is a child looked after that is always the how should I say, the stereotype of children looked after, they always say children looked after, they are the worse children in school, they say, oh if we were not told he was a looked after child we don't know...*

yeah, yes, yes, I agreed, the care plan for Benjamin has always been, lets say, because of his age we would always get his views, and he contributed and if he says, for example, I want to live with the cousin, we say, ok we will explore that and then explain to him why he couldn't, and his mum, he knows why because first of all he knows mum is very unpredictable and doesn't attend contact, often when you expect her she doesn't turn up so when I say you're not going back to mum he doesn't, I think in a way it kind of, what I believe by saying what I thought should happen to children looked after, that psychological...? ...in his mind he knows that mum would not be able to look after him (ok) but again there is still that love in him or something that makes him want to go back, which is a kind of wish to want to go back but it was really sad, he can't see mum, mum can't come to contact, no one is stopping mother but she, mother is stopping herself (Interview with social worker)

In contrast to the cases where the child was rarely mentioned, Cases F, H and M show that the child is very present in the social worker's mind during the interviews. It is clear that an emotional connection has been formed, the social worker having seen the child directly, spending quality time with them. This connection in turn seems to effect the care plan for the good. For example, there was minimal drift or delay in Case F. There had been drift in Cases H and M but they gathered considerable momentum when a new senior social worker took over the case (Case M) or when the case was opened up to wider organisational scrutiny (Case H). From looking at the interviews available, it appears that these social workers were less cut off from the children's perspective and suffering, had met the children and formed good relationships with them, therefore they were more able to think about the child's point of view (Cases F and M). They come across as less identified with the parents, preoccupied with their needs or overwhelmed emotionally. Only a few social workers describe spending time with the child alone, and seem to have a real connection with the child's emotional experience (This echoes Ferguson's findings from home visits and therapeutic work with children, 2014).

Case M sharply contrasts with many of the other interviews as the social worker, Wendy describes spending a lot of time with Paula, driving her to and from the paternal aunt's home, which was a few hours away. This reminds us of Ferguson's point about engaging therapeutically, with children in different settings such as during time spent driving the children around in cars (2010). This long journey seems to have provided the time and space for them to really get to know each other and for the child to become real in the worker's mind. It is clear from the interview that the social worker, who talks mainly about the child, has allowed herself to form an emotional connection with the child. The social worker can identify with the child's hopes and fears and celebrates the child's development (captured by the story about the trumpet). The interview is mainly about the child's needs rather than predominately worrying about the parent's needs. (The social worker is black South African so her he's and she's are used interchangeably at times):

Wendy: But anyway so here we had to make all the arrangements and I had to tell the child, you know what, your father has written back and it was some excitement. You know, I am just sitting back but you can see he is just excited and so

Anna: you remember talking to Paula about that?

Wendy: I do, I do, because before that, before we even knew about the father, before we even went to court, Paula used to tell me, I've got two dads (laughs) I've got two fathers...and this is em my father; she had, she had actually an identity kit of father...an identity photograph ...in her possession and she showed that and she was sad then (said very low and quick so I nearly missed the word)

The social workers demonstrates considerable empathy for the child and recognises the harm witnessing violence by the step-father on her mother had on her:

Wendy: Ah, he was up to no good, do you remember he was the man with the domestic violence and Paula was, you know, witnessed that and all the time and I think she worried a lot about mother...and she was frightened (again said very quickly that I almost missed hearing it)

The interview really shows the social worker is in sympathy with the child, observing her and talking to her at every stage of the care plan. It was a real pleasure interviewing this social worker, her voice was musical and lyrical. She understood the emotional significance of the child's experiences, understood what was important for the child and what would make the care plan work or not. Perhaps whispering the child's feelings signifies and captures just how unthinkable and painful these things were for the child, and almost too difficult for the social worker to articulate. They were whispered so softly that I had to go back over the tape many times before capturing the words. Again

in Case F we see a spontaneous demonstration of the social worker's connection with the child. It is in the immediate opening of the interview, effectively placing the child as the central to focus:

Parmjit...yeah she was about 8 months old, lovely lovely baby and full of life and joy and erm I think contact was an issue for her even at that age, because you know again mum kept cancelling it at the last minute and you know Mary would take her to contact centre only to find out that it was cancelled.

Case F, and J seem to be the only obvious cases where delay does not appear to be a factor either prior to accommodation or after accommodation. Both involve very young babies who were taken into care at birth. It could be suggested that in some ways it is easier to make decisions about very young infants as it is not difficult to comprehend the child's vulnerability. Babies provoke more anxiety in the system and risks are less tolerated as the consequences can be quite devastating. Therefore the organisation is more likely to consider care proceedings given the child's vulnerability. Decisions for babies are seen to be more urgent and given the resources and priority they are thought to need.

Projective Identification, Emotional Deprivation and Inter-Generational Abuse

In some of the interviews with the social workers the parent's needs predominated and there was little room to think about the child (Cases A, B and J are the best examples of this dynamic). In these cases the parents are extremely needy in their own rights, and are emotionally deprived from neglectful or abusive parenting themselves. However, in some of the cases the deprivation of the child or children also led to problems in keeping the focus on the care plan in order to achieve permanency (Cases B, K). Where the care plan for the child is successful the social worker is mainly focussed on the child, mostly to the exclusion of the parent (Cases M, P).

With an understanding of the effect emotional deprivation has on a case we can offer ideas about what would ameliorate this dynamic. It is possible that having an understanding of the parent's history would provide the social worker and professional system with an ability to 'diagnose' emotional deprivation, in order to achieve a 'third position,' leading towards objectivity and away from blame and condemnation (Britton, 1989). This may go some way to mitigate the ambivalence social workers feel towards the parents they work with. Woodhouse and Pengelly's thoughts are that the social worker's hatred towards their clients and the subsequent anxiety this provokes affects decisions about cases and distorts judgements. Having a sympathetic understanding of

how and why a parent has become disturbed and abusive due to their own disturbed parenting can be enormously helpful and puts their behaviour into some kind of context and perspective. A historical perspective allows us to see patterns and put into place realistic long term treatment and support plans.

However, paradoxically having an understanding of the parent's history can also leave the worker with another dilemma. It is almost impossible to view the parent as a victim and a perpetrator at the same time. If the parent purely becomes viewed as a victim without their own agency then they will be patronised and responded to as children. An attitude towards the parent could develop which views them as passive victims of circumstance and unable to change. Adult capacities and conscious choices about change may be overlooked and a sense of agency denied.

For example, in Case J the interview extracts vividly demonstrate the social worker's parental response to the mother's powerful projections. The social worker describes her as 'very, very vulnerable,' 'like a child' and that her actions remind her of a baby, sucking the thumb. The mother has become a rivalrous baby to her own real baby who then get's lost in the mother and professional's mind. The overwhelming nature of the parent's deprivation makes the social worker preoccupied with her, so much so that she can hardly bare to think about the baby. The social worker feels very angry with her managers for making her feel this way. Her sympathy for the parents and view of them as victims clouds her judgement about her own safety, making an inaccurate assessment of risk. Sonia story of origin is extremely painful. She obviously identifies with a highly deprived infant that was unwanted and nearly killed off before being born by her mother's addiction. Like Sue in Angela Foster's chapter about the deprivation of female drug addicts (2014), Sonia's story has a powerful effect on professionals around her and elicits a huge sympathy. This is the dynamic that Mina responds to and one that contrasts sharply and perhaps eclipses the fact that she has repeated her mother's actions by placing her baby at risk in the womb by taking cocaine.

There is an inherent difficulty in seeing mothers as both victims and perpetrators particularly when we are encouraged by policy and procedures to think in binary terms about complex matters. However, there is a further problem with seeing women as aggressors due to the idealisation of motherhood, leaving mothers who struggle with aggression and violence stigmatised, marginalised and without treatment (Welldon, 1999, Foster, 2013) In this case the social worker shows no signs of anger or frustration with the mother about her lack of care towards her baby. Therefore she either did not feel any ambivalence towards Sonia, or a more likely explanation is that her ambivalence is split off from her awareness and denied. The good, benign feelings are projected into the mother who is described as a 'sweet naive woman.' She is grateful

towards and admiring of Matt. There is no mention of the harm he has caused. Perhaps Mina's feelings of ambivalence, anger and hatred are displaced into the managers who become bad objects in her mind.

The findings in this study highlight guilt as a possible factor in the lack of progress in cases that become stuck. We know that facing guilt and taking responsibility is extremely problematic in borderline pathology and is linked to problems in emotional development caused by parental failure (Bower 2014). It appears likely that parents get rid of unbearable feelings by projecting guilt into the worker, who then prevaricates about the child's safety in order to placate the parent. For example, in Case J we see how the social worker turns Matt into a benign figure who the social worker states she is grateful too. Guilt is of course linked to shame and Walker argues that parents can't approach the feeling of guilt and responsibility without being helped to navigate painful feelings of shame first (2011).

Projective Identification

In Case K the social worker is eventually able to make a definitive decision about moving the child from an inadequate placement based on her recognition of the child's distress. This recognition denotes a connecting up with the child's subjective experience and a move away from defensive practice which distances the social worker from the child's distress. It is also possible that unconsciously the child and the social worker are unable to think about future and permanent attachments until the immediate deaths and losses in his life are dealt with. Also similarly to the dynamic in Case J when the social worker is unable to keep two complex needs in mind (parent and child), it seems that Cheryl is unable to keep two processes in mind, i.e. how to help Lee with the losses in his life, while still thinking about his longer term needs. His short term needs are hugely pressing and urgent and there is literally no time or space to think about care planning.

Therefore the importance of a distanced, strategic process (in this case the adoption panel) became crucial, so that thinking for the social worker could be undertaken. Until then organisational mindlessness resulted in ill thought through knee jerk plans for the child, which resulted in Lee being bounced from one emergency, temporary placement into the next with little thought about his longer term needs. This case study shows the dynamics behind multiple placement breakdown, and highlights the type of therapeutic preventative action that can be taken in order to break this cycle of 'system abuse'.

In this organisation the two needs (the child's and the parent's) do not seem to be able to be kept in mind or responded to as a whole. Instead they have become placed in binary opposition with each other, reflecting an unhelpful split in the parent-child dyad. This echoes a further split we can see between the care and control elements of the case, with care being evacuated at the expense of control. Being 'child focussed' therefore has

paradoxical, unintended consequences in this case and almost results in the opposite effect. One thought we came up with in clinical supervision was that I was brought in to be a parent to the 'wayward' social worker who has become identified with the out of control young woman. Mina is 'taken into care' metaphorically by me through my assessment and settles down, making the right decision for the child in the end.

Summary of Instances of Projective Identification;

- Social worker identifies with the parents, through parent's appeal and need for help (parents are experienced as deprived children). The real child gets lost (Case A, B, J)
 - Social worker identifies with parent's inability to think about the child's needs - Parent's state of mind is mirrored by the social worker (Case C, D, K, P)
 - The social worker identifies with the parents as a way of coping with the level of hostility and aggression. This is a way of appeasing the parents and would be expected in cases of serious domestic violence (Cases C, E)
 - Social worker becomes paralysed by guilt, projected into them from the parent who is unable to tolerate their guilt (Case A, B, J)
 - Social worker identifies with the deprivation in the child, becoming overwhelmed (B, K, L)
 - Organisation/SW turns a blind eye to concerns, resulting in organisational mindlessness (C, D, I, K, M, N, O, P)
 - Social worker has inadequate understanding of children's emotional development (A, B, C, D, K)
 - Pressure from borderline dynamics, huge push to agree with parent's point of view (A, B, C, E, G, I, M, P)
 - Evasion by the parent thwarts the social worker's efforts (D, E, F, G, K, M, P)
- Consequences of not Keeping the Parent in Mind

As already mentioned there are serious consequences of only focussing on the child at the expense of the parent. For example, in many of the cases the social workers describe the mother going on to have multiple pregnancies (Cases F, I, J). One thought is that the parent's failure to mourn results in an attempt to have replacement children with tragic results. Desperate women have late abortions (Cases F and J) and in this way the cycle of deprivation and abuse is continued. In some ways it could be said that the system acts out a sadomasochistic dynamic with these women, aggravating the deprivation Foster highlights in her account of female drug addicts (Foster, 2013). The most extreme outcome for one of the women I worked with was that she was murdered by her partner, who was the father of her second and third child. One of the good things to come out of this terrible tragedy was that a serious case review resulted in an important change policy in local authority practice. Young women aged 18 - 21 who had previous experience of being in care were considered as needing care and were accommodated with foster carers alongside their infants. These foster carers provided a

level of emotional support and parenting towards the women who then had a better chance at caring for their children. This was a progressive and welcome change in policy.

‘Keeping the Child in Mind’

In Cases A, J and K the child’s experience is largely absent from the social worker’s mind, as if the worker has become cut off and highly defended against any emotional connection with their reality. This may be down to the fact that thinking about the child’s experience is too distressing for social workers, a point Rustin (2005) makes about a natural human desire to avoid mental pain. However, it may also be that social workers have varying degrees of skills in communicating and playing with children (Ferguson, 2014). It may also be down to high caseloads, where emotional investment in each child becomes impossible across a case load of 20-30 children (this is usual in my experience of providing reflective supervision for social workers).

In my experience as a social work teacher and supervisor, becoming overwhelmed and preoccupied with the needs of the parents at the expense of the child is extremely common (Teaching in case discussion seminars at RHUL and work discussion seminars at the Tavistock Centre). Ferguson researched what social workers actually do during home visits and found that 30% of their time was spent with children alone. Although there are a number of reasons for this, including high pressures on social workers due to timescales and poor skills in communicating with children, it is my conjecture that it is because the vast majority of parents will be extremely vulnerable people who unconsciously vie for the social worker’s attention during a home visit. From my practice experience and discussions in clinical supervision deprived parents welcome the assessment so that there can be some focus on them. Some parents get better during the assessment process only to return to problematic behaviour towards the end of the work. It is not surprising then that desperately deprived parents will seek the attention of the social worker, someone who can help and understand them and this occurs at the expense of the child.

Brandon et al repeatedly found that in cases of serious harm that the child becomes invisible or lost to the professional with the system becoming enmeshed with the parent’s way of functioning; chaotic, overwhelmed and unable to think. They raise concerns about the way recommendations are made about further training and procedures without a tackling the underlying dynamics with reflective supervision and support (2010 Pg 1) Rustin raises concerns about the training of social workers in talking and listening to children and worker’s skills in observing and interpreting children’s behaviour. Bower links this difficulty with the lack of training and knowledge about child development (private discussion).

One thought is that if the child does not exist in the parent's mind that this becomes mirrored by the social worker. This may be linked to whether the social worker sees the child directly, or has spent quality time with the child in order to become familiar with their needs. From the interview material the social workers don't seem to have much of a connection with the children (Cases A, B, I, J, P). In Case K the social worker goes on to develop a good connection, as she is present for him during significant events such as the many losses he suffers. Towards the end the care plan progresses well as a result. Therefore, it is possible that an emotional connection and authentic engagement with a child progresses their care plan considerably. If the child can come alive and be kept in mind the social worker's relationship and understanding leads to progress and resolution.

Borderline Dynamics

Borderline states of mind and personality disorders are probably one of the most common types of mental illness children's social workers will come across. However, social workers receive little if no training in this area and are left to discover the disturbing effects of working with personality disorders through the course of their work. They will be lucky if they have a community mental health team worker advising them, or a consulting psychiatrist working with the parent affected by mental illness, as much of this type of illness goes undiagnosed and therefore sadly untreated. It is important to know the effect borderline states of mind have on social workers and care plans. In Case A we saw the changing views of the parent directly affect the plans for the child, and the social worker's ability to reach clarity about the best care plan. Mother's problems in intimacy and experience of rejection as a child was replayed with the baby, over and over again.

Dynamics of Addiction, Dissociation and Organisational Mindlessness

Both Maude and Sonia had chronic drug and alcohol addictions. I have attempted to demonstrate how the dynamics of addiction, in particular dissociated states of mind get mirrored by the professional system who lack concern for a child who is abused when living at home and who goes on to be neglected whilst living in care. My Role in the Organisation

The thinking about my role in the organisation was assisted by the research seminar group, a reflective group that met fortnightly during term time, where material from the interview transcripts was presented. A male social worker in the transcript relating to Case P used the phrase 'rule in or rule out' in relation to what he considered my role to

be. This phrase indicated that it was my role to do the thinking for them, to deal with the mess and see the abuse while they could go on denying it, or stay out of contact with it. Therefore, I was there to sanitise the experience for them. The social worker in Case P comes across as disconnected from the significance of the harm the children experienced in their father's care whereas I assessed both physical and sexual abused by their father and understood that this was the reason they would not meet with him. The social worker turns physical abuse into a culturally relative concept about 'chastisement' learnt through his own experience in his childhood. He does not mention sexual abuse. The social worker was quite distant from the children, whereas I listened to what the children described to me and observed their interactions with each other during a number of contact sessions. It was very clear to me that they were describing severe experiences of abuse which were being denied by the professionals in the case.

My role also ensured that they could remain disconnected from the pain of making a decision about the child, and all the anxiety could be pushed into me. In this respect the social worker could by-pass the emotional component of decision making therefore avoiding guilt. In Case K it appears that I am also used as a 'fall guy' by the legal department, who were concerned with avoiding blame and responsibility for taking the matter to court unfairly because the mother was ill. They did not want to be seen in a bad light. Therefore, I could be blamed if the care proceedings went wrong.

In some of the cases I also seemed to be used as a front man by the social worker and her manager, taking the full force of the parent's hostility and aggression. Therefore, the most extreme emotions such as fear and the parent's dangerousness could be absorbed and experienced by me instead of them. This did leave me feeling exposed and emotionally damaged at times, particularly when my safety was not taken seriously. This was particularly the case in Case B when I visited the father and he was high on crack cocaine. Experiences like these left me with the 'rubbish bin' feeling that Woodhouse and Pengelly (1991) describe.

My other role seems to have been to fill a skills shortage in the social workers who were mainly newly qualified or inexperienced in care proceedings. My assessment skills were missing across the wider children in need teams, senior management recognised this and alongside my role as an independent parenting assessor I was commissioned to undertake coaching and mentoring work. This was a constructive and creative development and demonstrates an awareness by senior management of the needs of their social workers.

Summary of What Leads to Cases Becoming Stuck

There were a number of themes arising from the interviews highlighting dynamic causes behind why cases became stuck:

- Projective identification - particularly projected guilt, the worker responds to child-like qualities of parent and/or the deprivation of child or parent overwhelms the worker (Cases A, B, J, K, P)
- Emotional impact on worker - creating a possible desire to remove themselves from the case leading to multiple workers (Cases B, C, D, E, L, N, P)
- Not seeing the child alone or connecting with the child on an emotional level - linked to defensive practice (Cases A, B, C, D, I, J, K, N, P)
- Organisational dynamics (Cases B, C, D, K, L, P)

The following themes were ‘around’, i.e. inferred but not explicitly touched on. These would be good themes for further research.

- Reparation, why people go into social work in the first place/Putting things right that can’t be fixed
- Lack of training in mental health, child development and poor skills in assessment
- Nature of decisions - certainty/uncertainty

Summary of What Leads to Improved Decisions and Outcomes

- Good model of assessment taking in key factors, highlighting risk and the capacity of parent to change (Chronology, duration and nature of concerns, history of abuse, addictions, mental health, domestic violence, observations of relationships and parenting)
- Identifying patterns in cases
- Using Genograms - using parent’s history as a third position
- Theoretical framework (psychoanalytic) in order to understand the nature of psychic disturbances
- Understanding of mental illness including borderline personality disorders, depression and psychosis
- Assessing harm and likelihood of harm
- Independent supervision - free from organisational dynamics
- The third position/triangulation - perspective and a fresh pair of eyes
- Seeing and connecting with the child

Keeping the Parent in Mind - The Consequences of Failing to Support the Parent

While there was great difficulty in keeping the child in mind when the parent had overwhelming needs, there is also in a number of cases, little or no mention of the mother, and in particular no discussion of her support needs. In the interview material in Cases H, K, M and P. It is the mother who has become 'lost' and hardly to be mentioned in Case M, and quickly dismissed in Case P, where the social worker deals with the issues of the mother at the start of the interview and does not talk about her again:

Anna: So if you could just update me on all of the children, possibly starting with Benjamin and we will go through all of the children if possible.

Osiris: Well with Benjamin, starting with the care plan – the care plan was no rehabilitation to mother, mother was ruled out because mother did not follow your assessment even attend your assessment as you rightly point out. Mother did not engage and did not engage and never engaged with the Local Authority (LA). I think sometimes in November 2007 she came in and em informed us that she was abusing cannabis but did not accept - ? - occasionally she drinks but em that she was suffering from depression. She doesn't feel able she able to care for the children. But in any event that she would support the LA children to be looked after by the LA on a permanent basis

What all of the mothers in these cases have in common, are serious problems with alcohol or drug addiction and this appears to lead to a situation where they are dismissed quite quickly from any further consideration. There is little if no mention of the mother's addiction needing to be treated or an exploration of addiction support services. This links to Foster's (2013) who would explain this as the system mirroring the deprivation of female drug addicts, with overly harsh agencies re-enacting the internal sadomasochistic dynamics of the female addicts themselves, resulting in multiple layers of deprivation. In these cases the parenting assessments did take the parents into account, including their histories and views, but it was only through clinical supervision that I began to reflect on my own lack of thinking about the parent's longer term needs when forming the recommendations. As a result of the supervision I began to develop recommendations that were more meaningful for the parent, involving longer term therapeutic interventions and support to the mothers or fathers, whether the child remained with them or not.

In order to address the problem of keeping both sets of needs in mind I propose a different model of approach for children and families social work. With such potent psychodynamics at work, it seems unreasonable to expect a sole social worker to keep both sets of needs in mind. An approach involving dual working or a team around the family would be more appropriate and effective. New initiatives like Pause or Family

Drug and Alcohol Court seem more applicable. Diagram 5 shows how the mother (and ideally the father's) needs can be kept in mind alongside the needs of the child.

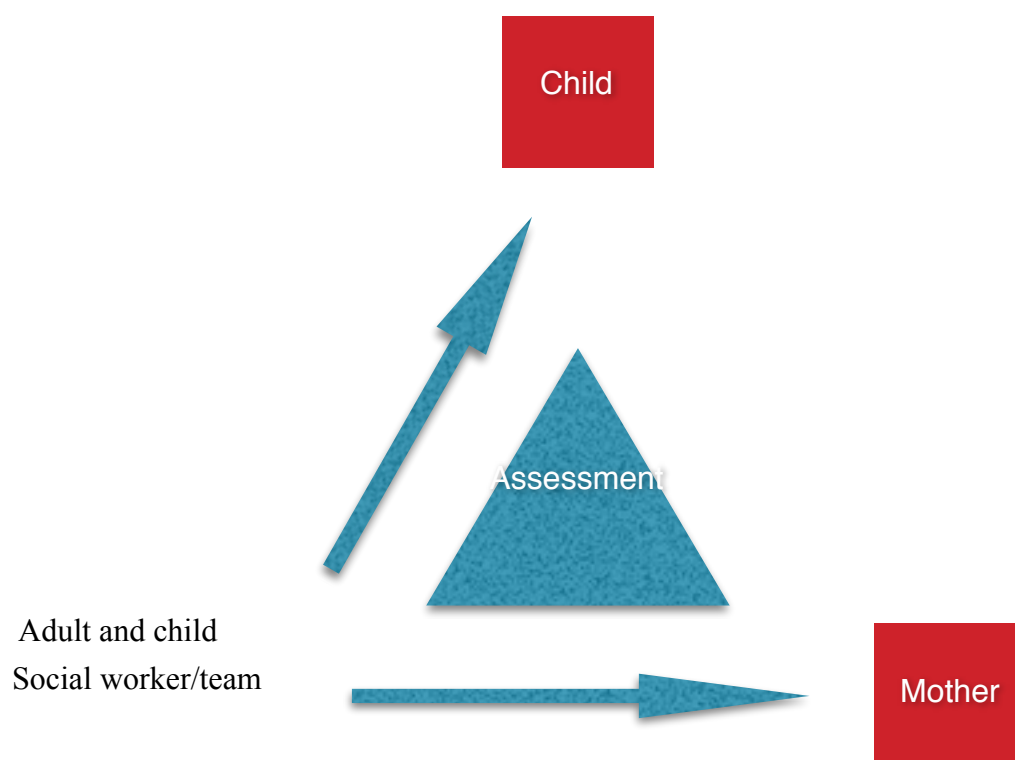


DIAGRAM 5: THE PARENT-CHILD DYAD

Late Abortions and Multiple Pregnancies

Late abortions, lost babies and multiple care proceedings are pretty horrific outcomes for the women involved in the study and very difficult emotional experiences for the social workers to process. There are potentially even further repercussions in failing to target support to this vulnerable group of parents. In one extreme case, (I) the father killed the mother following her third baby being removed. This was a highly unusual case for me, because I was asked to assess not just the mother but the maternal Grandmother and maternal Great Grandmother. I then assessed the father who went on to murder the mother. Consequently, I built up a rich, multi-generational picture of the problems and relationships in the family.

In Cases F and J we are reminded of the consequences of not offering the parent support in their own right. In a small but significant cluster of cases multiple pregnancies and occasionally multiple care proceedings occurred (Cases F, I, J, O). In the opening lines of the interview in Case K the social worker, 'Parmjit' recounts a horrifying experience she has of a case in which the mother becomes pregnant again:

Parmjit: God I think my memories are just so vivid - I remember reading about it and funny thing after Chanel was born same thing happened so it was again you know, she fell pregnant...almost straight away and er she ran away from her, she left her on her own and it was actually...I think that was quite traumatic for me...because erm I found out that you know she was pregnant, she was no longer living at the address in * and then after sort of you know doing sort of you know further digging and eventually she'd been staying in her flat share with a friend

Anna: That's right.

Parmjit: ...and obviously we knew by this time she was pregnant, or that she was doing her very best to conceal her pregnancy for a long time

Anna: How did you know that?

Parmjit: I think that I went to see her er when she was at the family centre when she was pregnant and she mentioned it that she was pregnant, she kept changing her stories and that's when, that's right we were actually in court erm with Chanel and you could see it you could see that she was pregnant but she was trying very hard to sort of keep it up under wraps but erm she did eventually admit that she was pregnant. Her mum also told me. Mum was very very concerned er that you know what was going to happen to her and this unborn child as well, so obviously I sort of liaised with * and then I think when I saw her or even before I saw her I think * er then sent

Anna: That's the child protection team kind of thing

Parmjit: Yeah, when they saw her they said she wasn't pregnant

Anna: That's right, so disturbing wasn't it?

Parmjit: Gosh, it was truly disturbing

Anna: So you had seen her in court and she was heavily pregnant, like how what?

Parmjit: I would say like 5, 6 months, I would say 5 months at least because she was showing, she was actually showing. So when the police officers went to visit her she was not pregnant and so you know obviously then the grandmother kept phoning saying 'we want to know what's happened to this baby'

Anna: Absolutely, gosh!

Parmjit: Erm but mum denied that she was pregnant. But we know for certain that she was pregnant. And in fact I was even going to take her to her GP to get her pregnancy test. Actually yes, I think one of your recommendations was that you know that she continue to have the drug testing done and again I'd arranged an appointment erm with her GP in * to her be tested, to have the drug testing done in the GP surgery and again you

know the GP surgery may know the preparations and everything for her to be er and she never turned up but I yes, the traumatic thing was when the police officers went to see her she was no longer pregnant so you know obviously the questions were 'what's happened to this baby'. I had sort of lengthy conversations with her GP and GP said that you know if she was about 5 months pregnant then that's you know, you can't then have a miscarriage she would have had to have given birth to a stillborn baby or maybe she's given birth to the baby and you know she's managed to get rid of the baby somehow. So that kind of puzzled

Anna: *That's really disturbing wasn't it?*

Parmjit: *Oh god, I, I still to date you know remember feeling quite sick in my stomach at the thought what could she have done with this baby? ...I remember we had a strategy meeting and I remember one of the police officers saying 'she could have done anything with this baby, maybe you know the baby could have been stillborn or you know maybe she just sort of wrapped the baby in bin liner and chucked it in the dustbin' and I this is a human being we're talking about! But yeah it was very very disturbing but I mean I think again that again just sort of indicated just how far gone mum was in her drug use that er that you know she was just not ready to accept help..."*

In Case J the social worker captures the awful sense that nothing has changed:

...well, I believe she did have, she did become pregnant again after A was placed for adoption but she did abort the child (ok) soon after.....and the letter box woman has called at the flat a few times and she says that it is still in disarray and it is still ongoing

Both cases are similar in that the women seem to have frighteningly late abortions. In Case J:

Mina...*well I did tell her about the repercussions about what would happen if she got pregnant and I think she did realise that because the fact that she had an abortion, I know with her second or third abortion, well, her third pregnancy, because she had one (oh did she) she's had two I believe she's had two abortions (yeah) and then she had A but the things is erm, (pause) with her abortion I think she had left it very late, extremely late, so I don't know what was going on there but I think we, as a department we do need to look at that, we need to look at the support that the mother needs...*

The Emotional Impact of the Work

"When we are nurtured, supported and not too shocked, we can more easily notice the patterns of our relating to our clients. We can be more alert to the way in which these patterns might mirror our clients' experience of life, and then use what we notice to further our goal in the therapeutic process. When

we are unsupported, un-nurtured, scared, frightened and sad, we become less able to notice our own involvement in patterns of relating, and less able to find a niche in which we can be compassionate to ourselves.” (Sarah Margaret Mills, 2011)

The interviews with the social workers in this study were long, in depth and rich, eliciting a wide range of information about the outcome for the child and the progress of the case. However, all of the social workers used the interviews and the space they provided to tell me a story about the emotional impact of the work, and the things that they found particularly difficult. Most of these stories were hidden and previously untold. The social workers seemed relieved and grateful to be able to tell them, to make a meaningful connection with another person who understood what they were trying to communicate. In this way the interviews acted like a debrief for social workers who had not had the opportunity to ‘off-load’ before. Although the interviews were semi-structured with pre-set questions they were open and responsive enough to allow the emotional factors to emerge. It is clear that a high level of trust is developed towards me, where they felt their story would be valued and understood. Painful feelings are explored in a relatively safe environment where I am viewed as a helpful insider and have developed relationships with them to one degree or another. I have been involved in the same messy business as they have, so I am viewed as already having a level of understanding of the situation and sympathy towards them. Where I was not initially viewed as someone to trust and the social worker was more guarded, like in Case J, my careful attention to the emotional aspects of the work during the interview, encouraged a deeper expression of the emotional impact of the work and a relaxation of their defensiveness.

What is remarkable about the interviews is how powerfully they highlight the sheer force of the impact the work has on the worker, and how disturbing the realities they are expected to process and cope with really are. The traumatising impact on the worker can be seen in Cases F, J and K. The social worker in Case F reports ‘vivid memories’ and the social worker in Case J reports finding the work very difficult indeed. In Case A the social worker reports that she received the backlash from my report when the mother is told that I recommended the baby should not return to her care. Generally the interviews are filled with reports by the social workers, of finding themselves in highly unusual scenarios which are dramatic and make for gripping interviews. The interviews are imbued with heavy emotion where social workers and interviewer are fully immersed in what is being discussed. Although the interviews were ostensibly intended to explore the factors affecting decision making, most of the social workers took the opportunity of having an emotionally available mind to tell their story, regarding their deeper thoughts and the feelings involved in the work, exploring the complexities and uncertainties of the work and revealing the horror and pain of what they had been involved in.

Another theme coming out of the interviews about the emotional impact of the work is emotional consequences of being faced with the idea that sometimes parents can't be helped, they refuse help, or even see help as the problem (Bower, 2005). As already discussed, some parents get worse and even die. Is there a point of realisation for these social workers that despite their best efforts people will not respond in the way that they want them to. What do these feelings of disappointment or helplessness do to the social worker? Scanlon (2015) describes them as traumatising. Can they recognise and live with the limitations of their effectiveness (Mattinson and Sinclair, 1979). This seems to be the main struggle for a number of the social workers in the interviews, and the interviews seem to be a vehicle for processing these deeper feelings of conflict about the work (Cases A, F, J,K, M). It is not so much that the social workers struggle with the decisions they make regarding the child but that they face huge difficulty in processing the tragedy of the individuals and families they are involved with. This is also often aggravated by the adversarial nature of care proceedings where parents are set up against the interests of the child, with the child and parent considered to have mutually exclusive concerns. Therefore, there is little emotional space given over for care and concern for the parent for cases within care proceedings.

Parents often have serious psycho-pathologies, difficult or disordered personalities, histories of abuse and neglect, problems with aggression and addictions. all of which make it difficult if not impossible to effect change. Some parents are suicidal or involved in violent relationships which lead to death. These disturbances are very powerful and really unsettle the worker, who has to cope with the emotional impact of the work and come to terms with damage done to children that they are in close contact with. The despair, hopelessness, or helplessness they may come to feel in the face of chronic, intransigent problems, can lead to disillusionment and a desire to get away from the work. Social workers become cut off emotionally towards children, disconnected from parents, angry with managers, hostile and dismissive towards other professionals and unable to make clear decisions. They often move jobs and hope that the next job will afford them some relief from the work. However, in each new job they will come to realise that at times they can be faced with the same intractable problems as before.

Social workers identify with different elements of pain projected either by the parent in distress, or by the child who is unable to think about an articulate their experiences in any other way than through 'behavioural difficulties'. If destabilised by projections and a projective identification with infantile parts of the parent or child, social workers will find it difficult if not impossible to have a realistic empathic stance towards the parents.

If they do not have a theoretical framework for understanding human problems then they don't have a helpful framework to help them think about the primary task i.e. child abuse. It will be difficult to resolve issues relating to negative transference. What I mean by negative transference is some of the powerful projections from clients, such as hostility, deception, covert or overt threats of violence. A helpful theory would also help workers to recognise their limitations. Without a theory that explains projection and projective identification social workers are more likely to blame themselves for the failure of their client's ability to parent and allow displaced feelings of guilt affect their judgements.

I have discussed the underlying factors that give the work an overwhelming nature. I have explored projections, projective identification and negative transference in the interviews with the social workers. In this way I hope to formulate a knowledge base for relationship based practice that acknowledges and understands 'pathological communications' and what they mean (Ferguson, 2014).

Problems of Assessment (What the Parent Wants You to Know and What the Unconscious is Telling You)

During the research we have seen examples of where it has been difficult to make accurate assessments of risk due to the confusing and sometimes contradictory nature of the presenting material. Often what is being presented to you by the parents is contradictory to what is known from social work or police records. This is particularly the case with addictions, where the problem can be hidden and denied even in the face of quite obvious signs of continued drinking/drug taking. However, denial about a problem is quite common and not difficult to navigate if the professional system is working and professionals share their experiences of the family. However, some problems of assessment are more tricky and confusing. For example, in 'Attack Dogs,' were the mastiffs safe around children as the parents wanted me to believe or were they not? The children chased one of the mastiffs around the dining room to prove it's safety, a scene set up by the parents to make their point. However, it made me feel that this was even more of a risk as the parents offered me a mad assertion over reality. In the case where a father showed me the picture of his dead friend who committed suicide, I was also being urged to agree with the parents that there is no cause for concern about the care they are providing to their son, despite the disturbing nature of their unconscious communications. The countertransference response in me was one of deep shock and disgust on seeing a dead body with a slit throat and a growing awareness that the father was a highly disturbed individual needing to project something unbearable into me.

There is a tension between reality and fantasy and surface and depth. How do we interpret presenting material? How worried should we be about material such as the dangerousness of dogs as opposed to the reasonableness and ordinariness of having a dog. How do we discover hidden aspects of a case where turning a blind eye or sweeping concerns under the carpet prevail? How do we keep our own counsel when there is a huge pressure to agree with the parent's point of view? These are aspects of assessment which are not rational, clear cut or commonsensical. This shows the confusing and destabilising nature of the task of assessment.

Summary and Conclusions of Findings

The interviews provided evocative and convincing accounts of the emotional impact cases had on the social workers. In Case J the trauma of being present at such an intimate moment when the mother is supposed to bond with the child, seems to have subsequently paralysed the social worker, filling her with anger towards her managers and the organisation for not allowing her to be helpful. The underlying fantasy (and perhaps the reality) appears to be one of destructiveness, and that her presence prevented the bonding process between mother and child. This together with the shock and guilt of a previous suicide by a mother she was working with a few years before would have left Mina terrified that it would happen again, and unable to think or act decisively about the child. In Case K the emotional impact of the work on the newly qualified social worker is like a rollercoaster. My heart was in my mouth when listening to her descriptions of the trials she went through supporting a vulnerable 6 years old through multiple losses even adults would find difficult to process.

Social workers were often young, newly qualified, White or Asian middle class women. The situations they encountered were extraordinary and deeply disturbing. Sometimes these situations involved extreme phenomenon such as the sadistic abuse of children, the removal of a baby from a mother at birth, the murder or suicide of a parent, late abortions and lost foetuses. These extreme circumstances contrast sharply with what social workers expect when they begin their social work careers, mainly going into social work with the expectation of helping people and tackling social injustice. The danger is that when social workers begin to realise and experience the disappointments and disturbances inherent in the work they start to defend themselves, either by changing job or distancing themselves emotionally. These are the complex, unconscious reasons for problems in retention in social work.

The work depends on the social worker recognising and being able to engage in other people's emotional pain without becoming identified or overwhelmed and keeping a piece of ground of their own. It means connecting up emotionally with the child's

reality and often the tragedy behind the family's problems. This takes courage, insight and fortitude. Defences against anxiety and psychic pain are understandable and necessary but need to be ameliorated by supervision that is cognisant of the emotional impact of the work on workers. This is necessary if meaningful relationships are to be formed as it is only through emotional connection with the child or parent that real change occurs.

Disturbances in parents also need to be engaged with and tools for social workers provided so that negative transferences can be understood for what they are, worked with and expected, rather than split off, avoided, denied or ignored. It is often through recognising the negative transference, understanding the meaning behind our emotional reactions and thinking about difficult subjects that containment can be achieved. During the course of the research new and important insights into social work emerged about the kind of containment that can be offered to social workers, in order for them in turn to provide containment to service users. In the next Chapter I offer my conclusions, highlighting the implications for practice from the findings.

6. Conclusions and Implications for Practice

Introduction

In the conclusions I will highlight the main findings from the research, presenting the important insights learnt from the retrospective analysis of data in Part One of the research based on the information in the parenting assessments. I will then go on to review the themes arising out of the interviews with the social workers from Part Two of the research. I will show what we can learn from linking the themes arising from Part One with the themes from Part Two, offering an understanding of why cases become stuck over many years and why decisions may be difficult to make due to the unconscious processes involved.

As the research developed the questions moved away from being solely about an evaluation of my practice and a review of the outcomes for the children I had been involved with. It became much more about identifying and describing the patterns and themes families handed down the generations through unconscious processes such as projective identification, the impact this might have on the parents in the present and their relationships with their children and professionals. It then moved on to the deeper exploration of the subjective experiences of the social workers and their experiences as identified in the interviews.

Findings from Chapters 3, 4 and 5

In Chapter 3 we saw how an examination of the duration the cases that were referred to me highlighted how stuck some children had become in the care system, often remaining in short term care solutions. Psychologically this would cause the children in these temporary situations much uncertainty about their future. There seemed to be a particular constellation of background factors such as the predictable set of factors referred to as the toxic trio, addiction, mental health problems and domestic violence. However, my examination from the information gained through the parenting assessments also highlighted the high incidence of intergenerational abuse in the background of the parent. It is my view that addiction, mental health problems and relationship difficulties between parents originate from these difficult experiences in the parent's background and should be viewed as the symptoms rather than the cause.

Therefore, any attempt to treat the presenting problem without addressing the parent's history, their need to obliterate the pain through drugs or alcohol, their reasons for getting into abusive relationships, and the originating factors affecting their mental health, will be futile. Seeing the parent within their family and historical context is complex and will take time and skilled work. However, contextualising the parents' difficulties will help develop a therapeutic, compassionate approach to our work which is more likely to effect longer term change.

In Chapter 4 through case studies I explore psychodynamic processes common to child protection cases, which describe the kind of pressures social workers face in their work. These pressures, overt and covert, conscious and unconscious, have a significant impact on how the case is managed and what decisions are made. In case study A the parent places huge pressure on the social worker to agree with her and successfully makes the social worker feel guilty about withholding the child from her, rather than connecting up about her own ambivalent feelings towards her baby. Successive and last minute changes of mind by the mother makes it difficult for the social worker to step back and gain an overview about the best interests of the child, as she becomes gripped by the mother's confused state of mind. The mother's ambivalence was too difficult for the social worker to think about and was split off from her awareness. This resulted in an overriding certainty and a drive to return the child home despite the fact that in reality the mother was not ready, changing her mind just as the baby was to be returned to her care. This case study, I argue, captures the dynamics of the borderline state of mind, which has at its core problems of intimacy. This is a relatively common experience in child protection work and has wider relevance for social workers working with mothers who suffer from mental health problems of this kind.

Case study J describes the dynamic whereby the mother and social worker become taken over by a maternal transference, projected powerfully into the social worker by the emotionally deprived mother. Instead of these processes being recognised as an integral part of the process of developing a relationship and being worked with, they are denied by the organisation who, according to the social worker, wants her to focus solely on the child. However, ironically, this has the opposite effect as the social worker feels guilty about not meeting the mother's needs and angry with her managers. She is unable to keep the child in mind, potentially leading to heightened risk to the baby. In case study K we have almost the opposite effect. The child is emotionally deprived and projects his needs into the social worker so that the mother falls from mind. The child's placement journey becomes long and drawn out as he seems to be neglected by each carer. The social worker appears to be identified with him, as a deprived child and unable to mobilise her adult capacities and the significant resources of the local authority, until the adoption panel provides some thinking and containment, resulting in

a suitable family being found and supported with his complex needs and aggression. The successive deaths of Lee's older brother, mother and father remind us how deadly addictions can be. Lee's losses are huge and incredibly painful to think about.

In chapter 5 we review the themes and patterns from Part One and Part Two of the research, trying to link the finding about drift and delay with what we learn from the interviews. Unconscious dynamics such as projective identification are explored in more detail. The triangulating effects of the parenting assessments is apparent and offered as a model of practice that keeps the parent and child in mind as a connected pair. The tragic outcomes for the parents and devastating effects of continuing problems with addiction, mental health problems and domestic violence are captured in the story of the murder of the mother in Case I and the continuing problems with repeated child removal in Case F, which traumatises the social worker and possibly the wider systems of care.

Returning to the Research Questions

In the following sections of this chapter I return to the research questions to summarise the main findings of the thesis and make suggestions about an approach to child protection practice which ensures good decisions are made in complex child protection work. The research questions were articulated in Chapter 1 and can be restated here:

Research question: What are the emotional and unconscious factors involved in child protection decision making?

Subsidiary research questions:

- a) What are the dynamic processes involved in child protection social work, including cases that have become 'stuck'?
- b) How can common themes and patterns across the families be characterized?
- c) What emotional impact does child protection work have on the social workers involved?

An Exploration of the Emotional and Unconscious Factors Involved in Child Protection Decision Making (Why Decisions Go Wrong)

The boy stood on the burning deck

Whence all but he had fled

(Casabianca, Hemans, 1826)

As this research shows child protection social workers experience intense and emotionally demanding circumstances while helping those ‘in need’ with their lives. They encounter pressurised situations where levels of responsibility for the future of the child and the family are great. Like the burning deck, the work is dangerous, emotionally demanding, intense and potentially traumatising. It can feel as if social workers are the last resort, particularly when it comes to difficult situations such as removing children from their parents or making an assessment about the child returning home or not. Social workers are expected to make clear, well thought through, rational decisions whilst under enormous pressure. This is a pressure arising from both external and internal sources. In some cases the decisions social workers make will affect the parent and child for the rest of their lives.

Social workers are of course adults with adult capacities, acting in wider professional systems which support their decision making. However, I have shown that social worker’s adult capacities and judgement can be destabilised by the emotional factors or unconscious processes involved in child protection work. Unconscious processes include; the impact of infantile projections of an emotionally deprived part of the parent or child which the worker can become projectively identified with; a pressure to act in a certain way by the parent through overt or covert hostility or the pressure to think in the same way as the parent due to the parent's difficulties being split off from awareness; resentments between social worker and line manager leading to problems in the organisation being acted out on the family. Under these circumstances it is perhaps not surprising that decisions for children can go wrong. It is our responsibility to understand the emotional and unconscious pressures, so that social workers can think about their emotional experiences and make well thought through decisions which are not just responses to unconscious factors.

The pressure to act and take the lead in making decisions about where children should live, usually falls to the judgement of the individual social worker. This will be in

dialogue with their manager and will be based on their observations and their perceived effectiveness of their intervention with the family. It will then be a matter for the court whether the care plan is agreed with or not. If the relationship between the social worker and manager is strained then decisions can be ill thought through, reactive and precipitous, reflecting the unconscious dynamics between the parties rather than what is in the best interests of the child. If the social worker is not supported effectively by their organisation or even by a social policy context that is cognisant of the difficulty of the actual primary task, then they are vulnerable psychologically, just like children, to the traumatising effects of the cases. In case J we see how the trauma of being unable to help a vulnerable mother affects the social workers judgement.

However, if the social worker is contained by the supportive framework of their organisation and a sensitive attendance to the emotional and unconscious factors involved in the work by their supervisor, adult capacities can be reinstated and decisions reached which keep the parent and child-dyad in mind. This will promote well thought through decisions which are made in a collaborative and supportive atmosphere. This requires a policy context fully cognisant of the complexity and psychological dangerousness of the primary task and which responds to this risk to the social workers by providing the kind of support that takes account of the psychological risks.

I have argued that there has been little research into the extent of the emotional pressures of complex child protection work, and the implications of unconscious processes on decision making. Fortunately, there have been movements and developments in this area, for example in the research being undertaken by Ferguson (2016), as discussed in Chapter 1. As we have seen in the majority of research into child protection social work the organisation and professional system tends to dramatically underestimate the emotional impact of this kind of work on the social worker.

The individualising nature of case work leaves social workers susceptible to being drawn into unconscious dynamics projected from the parent, usually at the expense of the child. When overwhelmed by the parent's needs arising from early emotional deprivation and neglect, it is nearly impossible to keep the parent-child dyad in mind without the right kind of help. I will describe what I consider to be 'the right kind of help' based on the findings of the research which are based on the lived experiences of social workers.

There were numerous identifiable unconscious factors affecting decision making in the interviews with the social workers. These included projection, projective identification, splitting, disconnection, transference and countertransference. One of the most striking findings from the case studies was how emotional deprivation in the parents had a

dramatic impact on the social workers' judgements, making it difficult for them to focus on the child. The parents' needs could predominate and overwhelm the workers. This raises the difficulty of keeping the parent-child dyad in mind in cases where the parent is seriously emotionally deprived due to their own neglect and abuse in childhood. There are serious consequences when the child becomes lost from view, as highlighted in many serious case reviews into child deaths.

This problem of seeing the child could also be reversed. In a number of cases we see that the child was the sole focus of the social worker at the expense of the parent. This was particularly the case in Case K, where the social worker was overwhelmed by the child's needs only considering the mother when she was dying. If the parent becomes lost there are serious consequences as the parent may have further children who are then neglected and removed, the parent may continue to engage in self destructive behaviours such as drug or alcohol addiction. In one harrowing case the mother was murdered by a violent partner. All of the parents continue to suffer mental health and addiction problems and receive very little help or intervention which addresses their longer term needs.

Projective Identification in Social Worker - Family Relationships

In part one of the research I have highlighted how there seems to be a reluctance by the organisation to become involved effectively in protecting a child, even in cases where quite worrying concerns are raised. I have called this 'turning a blind eye'. In these cases decisions seem to be unduly influenced by a covert threat or pressure by the parents. Social workers become avoidant of making decisions or taking action, in order to evade being plunged into the inevitable conflict addressing the concerns would give rise to. This would mean challenging a side of the parents they don't want to face in themselves. It is clear that open and direct aggression or hidden hostility and covert threat can affect decisions to protect children. There can be an identification with the aggressor to appease this sense of threat. I have also raised a possible link between the hostility and aggression in the family with multiple changes of social workers. However, the change of social worker in a case meant that I could not interview the leaving social worker to ascertain what it was that led them to leave. Therefore, this requires further research (Ferguson 2016 is currently engaged in research of this kind).

I have shown in Chapter 4 and 5 how dynamics arising from emotional deprivation in the parents have quite powerful effects on social workers in direct ways, strongly influencing their judgement and decision making capacities. Infantile parts of the

psyche are projected from the deprived parent or child into the social worker, in a maternal transference or identifications. When projections from the parent hold sway there is little mention of the actual child. Likewise, there can be projections and identifications with an extremely emotionally deprived child paralysing the worker's adult capacities to act with decisiveness. When identifications involve the child it is difficult for the social worker to access an adult part of herself in order to make decisions about the long term care plan, becoming projectively identified with a neglected child, bereft of outside/organisational or managerial help.

Social workers who identify with the emotional deprivation, pain and loss in the child can feel helpless and ineffectual, unable to come to any conclusions about what is the best interest of the child. However, there is also some evidence that organisations can mirror these identifications, becoming mindless like a parent with addiction problems. Thought becomes obliterated and cut off from the child. It is not until some higher authority, such as an adoption panel or senior manager's scrutiny of the case, or an independent parenting assessment that enables thinking to be restored.

It is important to explore the way defence mechanisms against anxiety lead to dynamics whereby the social worker distances themselves emotionally from the reality of the child and their experience. There is a clear difference in the quality of the decisions made about different children based on whether the social worker has made a good emotional connection with the child or not. When there is evidence that the social worker has engaged with and formed a relationship with the child then the child's care plan is more likely to progress to permanency.

One further idea about projective identification is exploring the effect guilt has on the dynamic between parent and social worker. It is clear that many parents avoid feeling guilty about their neglect or abuse of their child. Guilt is too difficult to experience and is split off from the parent's awareness to be projected into the worker. As explained in the discussion about unconscious processes in borderline cases, guilt is a particular problem in the parent's early emotional development and needs to be treated therapeutically, as such. I argue that the social worker becomes projectively identified with the guilt that cannot be faced by the parent and this leads to a confusion or paralysis in the social worker resulting in the parent's needs being placed above the child's. Social workers become caught up in feeling guilty about being harsh or punitive towards the parent and fail to protect the child.

Using Countertransference and Developing Containment

I have shown how my countertransference responses from the interviews were used as a way of understanding the unconscious factors involved in decision making. Using my countertransference responses during interviewing social workers enabled me to attend to and interpret in a way that acknowledged the emotional significance of what the social workers wanted to communicate to me. The reverie (Bion 1962) of the interview provided an additional space for the social worker in which to think about their work. My approach was characterised by the attention to emotional experiences, which seemed to lead to deeper realisations about the family and a connecting up with emotional significance of the work. I came to the view that the interviews show that the worker was often disconnected from the emotional significance of what they relayed, and were fragmented in their thoughts. It appeared that during the process of the interview the social worker was able to communicate and face the more painful aspects of their work, becoming more in touch with the tragedy for the child or parent and in this way the interviews showed how thinking and feeling in practice can become connected up.

Interestingly, the interviews functioned to provide space in which the social worker could reflect on their experience of the case, particularly the emotional impact of the work. They were then able to think about the needs of a parent or child in greater depth. This has serious implications for promoting a more humane and integrated way of practice. The use of reflective supervision combined with critical reflection will promote a capacity for ‘affective rationality’ harnessing ‘adult capacities’ in social worker’s with regard to their decision making (Hughes and Pengelly, 1997, Rustin, 2005, Fook, 2012, 2015).

Providing Containment

In contrast to how stuck the cases had become the parenting assessments did provide an effective way of progressing the case; towards the closure of the case in the less serious cases when the child lived at home, or towards permanency when the child was in temporary care. None of the cases stayed the same or continued to be stuck. Social workers were able to review their decisions about children in the light of the parenting assessment report. Where perhaps the focus on the child had become lost the worker became refocused, less identified with the parent’s needs and more with the child’s. It is clear from the interviews that the parenting assessments had a dynamic effect on decision making, providing triangulation, and a space for the social worker to think about the child. Linking to the Oedipus complex the reality of the child had been pushed out of awareness in the minds of the parent which was then mirrored by the social worker. Whereas the parenting assessments allowed the child to be brought back into mind. The parenting assessments relied heavily on observations of the child and

therefore social workers reading the parenting assessments would have had to reconsider their needs in the light of the evidence about the child's distress and the harm they had suffered. In this way social worker's could move out of an identification with parent in order to see the child again.

There were significant findings about therapeutic interventions that also worked for the families and children. For example, a social worker's counselling of a mother seems to have led to a situation that prevented repetitious pregnancies and subsequent children being removed at birth. Therapeutic work with prospective adopters improved the prospective adopter's capacity to understand the child and this prevented further placement breakdown and led to adoption. The work I undertook with a mother about her relationship with an abusive partner subsequently led to a separation from the father and the child's attendance at school dramatically improved.

Implications for Practice

Importantly it is clear from the interviews that the emotional deprivation in the parent or the child leads to powerful projections and projective identification which paralyses the individual social worker often leaving them unable to think clearly or take the protective action in a timely way. Therefore, I argue that what is needed is a model of parenting assessment that can 'diagnose' this intergenerational problem of emotional deprivation together with a model of reflective supervision that can take account of the resulting unconscious dynamics arising out of the direct work with the family. Given the difficulties of keeping all of the families needs in mind in complex child protection cases I propose two practice developments which offer models where splitting can be ameliorated and triangulation promoted;

A Model of Parenting Assessment and Family Support to Account for the Emotional Deprivation in the Parent and in the Child

This study raises the question of whether a single social worker with sole responsibility for a complex child protection case has the capacity, psychologically to keep both the parent and child's needs in mind. Traditionally it has been argued that one worker is required for all of the family, as the parent and child are a pair and the family needs to be worked with as a whole. However, this may make sense intellectually, but the question is whether it can be achieved psychologically, particularly in cases that are complex and involve high levels of deprivation in the parent or child. From the interviews the social workers struggle to divide their attention, particularly in cases of extreme deprivation. From the interview material it seems impossible to work a case of this level of deprivation by yourself over any period of time without either being

consumed by the adult's needs and unintentionally neglecting the child's or focussing on the child's needs and cutting off from the parent. Furthermore, if the parent's needs are ignored they are likely to go on to have further children, with the cycle of removal and deprivation happening repeatedly.

It is one of my findings therefore that children and families social work needs to be restructured along the lines of the child and family guidance model, where an adult social worker works with the parent and a child's social worker with the child. They can experience the identifications, then come together to think about these in a clinical team discussion. This is a popular model for family therapy using psychoanalytic principles. This also mirror a casework model similar to the one Woodhouse and Pengelly proposed (1991), where the workers for the parent and child reflect on their enactments in order to help the family as a whole.

The consequences of not keeping the child's needs in mind are well known and underly many of the messages arising from public inquiries into child deaths. However, in this study we have seen the consequences of focussing on the child whilst not taking the parent's needs into account with tragic consequences. Therefore, there is a need for a parenting assessment model which takes full account of the child and the parent, their relationship and both of their needs separately and together as a connected pair. Any parenting assessment needs to be able to 'diagnose' emotional deprivation, in order to recognise and mitigate the dynamics resulting from these difficulties and also in order to target the right kind of supports for the parents and child. This is a model which identifies the long term support needs of the parent, if the child remains at home or not.

From practice experience it is incredibly difficult to help some 'parents' or 'parental figures' (men and women) particularly when there are chronic problems with addiction, personality disorder and multiple pregnancy. In some ways I can understand why the women were so easily dismissed by the social workers in many of the interviews. However, as Foster (2013) points out the system replicates the deprivation of the female addict, leading to further marginalisation, and deterioration in mental health and addiction. In many of the cases I was left wondering whether the women I had worked with were still alive, as many addiction problems link to problems with self destructiveness. It can be short sighted not to think about the mother's needs, because many of the women continue to have babies and then have their babies removed, with all the suffering that entails for everyone (child, mother, father, social worker, other professionals, court).

Chapter 4 highlights the consequences for women when they are not supported after having their children removed and shows the repetitive nature of care proceedings,

including multiple pregnancies, late abortions and in one awful case, a woman's murder (Case I - see page 56). Finding out about the outcomes for the mothers in these cases led me to take a much more thoughtful response to highlighting their longer term needs in subsequent parenting assessments. Parenting assessments could not just make recommendations for children but also helpful recommendations for parents. I also tried to develop a post removal parenting intervention in the Local Authority.

There are a number of initiatives which have developed in response to these chronic difficulties such as PAUSE (www.pause.org.uk) and FDAC (Family Drug and Alcohol Court). PAUSE was set up in Hackney in response to the growing awareness that women who had their children removed needed a higher level of support if they were to avoid repeated children being taken into care. PAUSE provides a multidisciplinary approach to helping women at risk of repeated care proceedings. The support is both practical and emotional, providing contraception whilst offering counselling and supporting women with their housing, educational and employment needs. FDAC was an innovative court system set up in Wells Street, London by the judiciary, the local authority and a charity to respond quickly to the needs of families who come into care proceedings specifically with problems of alcohol or drug addiction. In these proceedings uniquely the judge encourages a relationship with the parents, encouraging and supporting them to make and sustain the changes they need. (See Appendix II for a description of these services.

With the help of clinical supervision, I was able to develop recommendations to include a closer assessment of whether longer term support could be offered, particularly in borderline cases or cases of huge complexity. I also offered ideas to the local authority about working with women who had lost their children to care proceedings through once a week group psychotherapy. Although the local authority did not take up my suggestion at the time, it is an area of practice that I would like to develop in the future.

I developed a model of parenting assessment which kept both the parents and the child's needs in mind (See Appendix I). The skills I developed in relation to infant observation enabled me to focus on the emotional needs of the child and kept them central to my work. This was supported through my tendency to see the child alone, forming a relationship with the child and observing them with their parent in the home. Clinical supervision helped me to recognise that I was neglecting the parent's longer term needs. However, I began to address this in my recommendations and it informed my assessments.

Implications for the Organisation

Just as we have seen that individual social workers and organisations can turn a blind eye to children's suffering, or the suffering of parents, so can managers and organisations turn a blind eye to the suffering of social workers. This research raises serious questions about what is going on organisationally, where managers are prepared to send workers out on dangerous activities with inadequate psychological, emotional, educational, or practical support. In terms of psychological support social workers who are traumatised will be unable to make good decisions for children. They may be likely to exaggerate concerns and risks or turn a blind eye as becoming involved is emotionally unbearable. Organisational dynamics can mirror the family dynamics, decisions and interventions become chaotic like the family functioning, identification with a parent or abuser can be mirrored by the social worker. Psychoanalytically unconscious dynamics are more complicated than the simple formulations of projection and projective identification.

Of course, organisational dynamics are set within a social policy context. In a context of austerity survival anxiety can produce a dynamic similar to a manic defence. This is symptomised by the accelerated work place, where doing is preferred to thinking and feeling. Work spaces become colonised by procedures, performativity and efficiency (Cooper, 2005), becoming places where thinking and feeling are evacuated. Despite the best attempts of senior managers and staff to counteract this even the best intentions will be defeated or undermined by unconscious dynamics.

A Model of Reflective Supervision: from Disconnection to Connection Through Feeling and Thinking

"...for the practitioners involved what is necessary is something akin to what in the social work field or in psychotherapy would be called professional, as opposed to managerial, supervision. It is a difficult and stressful thing to make these momentous, life-changing decisions in conditions of uncertainty, and to do so both quickly and in full awareness of the human implications for everyone involved. It will be hard to sustain in the long run without effective support of that kind." (Brandon, 2010)

Case A (Chapter 4) demonstrated how difficult it was to think clearly and make a decision about a child when pressurised by a parent who kept changing their mind. The social workers in Cases J and K (Chapter 4) were highly defended at the start of the interviews both in different ways. Mina (Case J) was covertly aggrieved towards her managers, coming across as cut off and disconnected from the child. Cheryl (Case K - see page 56) was open and engaging with me but she had become cut off from the emotional significance of the child's experiences leading up to and including his removal from his home. Thinking clearly in these circumstances and under these

pressures becomes impossible. However, there came a point (that I have called a critical moment) in each interview when the social worker became less defended and more in touch with the pain of the work. The shift of emotional tone seemed to indicate significant moments in the interview where realisations were made and a shift in the depth of emotional connection took place.

Both Mina and Cheryl shared their emotional experiences of the work in the interviews, describing disturbing or poignant memories which left me deeply moved due to the growing awareness of the pain behind what was being described. They were able to develop a real connection with the tragic contents of the case and feel the pain this realisation had for them. This ability to become more in touch with the pain of the case was supported by having an understanding person who provided a space, or 'holding environment' in order for them to share and reflect upon their experiences (Winnicott, 1973). This provided them with external containment. In turn the social workers were able to internalise a capacity for containment (Bion, 1962, 1970).

This process has important implications for social work practice. In order for social workers to be emotionally responsive and engaged with their work, which leads them to be able to think clearly they need a supervisory relationship that can offer containment. Psychoanalytic theory provides the concepts which help social workers understand the more disturbing aspects of human nature they come across in their work. A strong theory which is relevant to human suffering can in turn provide another level of triangulation and containment.

This idea links with another idea that emerged out of the interviews. As already described, unconsciously the social workers used the interviews as a debrief for the work in order to process the emotional impact the work had on them. Many did not have the opportunity to tell their story previously in full and the interviews afforded them with some relief. It seems self evident that this debrief should be another element of the support that needs to be built in to the system for social workers if we want to retain good workers to a point where they have developed a good level of professional judgement.

I found that clinical supervision from a senior social worker and psychoanalytic psychotherapist was the most effective way of helping me to recognise the re-enactments in the cases I worked with. It helped me to interpret what the emotional impact of the work meant and helped me to understand negative transference as part of the necessities of the work. It was useful to have someone independent of the case and the organisational dynamics, where thinking could be relatively free and objective. Supervision that is attendant to the emotional aspects of the work also provides a

supportive relationship where the social worker's dependency needs can be met. If the social worker is nurtured and their vulnerabilities understood they are more likely to meet the dependency needs of their clients (Bower, 2003).

Implications for Social Policy

As I have demonstrated it is almost impossible for the individual social worker to keep the child-parent dyad in mind without help. These findings have serious implications for social work practice. In the light of the findings I propose a new way of approaching child protection practice, particularly with regard to the kind of assessment which could reflect depth in complex child protection problems and a kind of reflective supervision that acknowledges the importance of emotions and unconscious dynamics. I describe two models of practice which will improve child protection work in the future, based on the parenting assessment model I developed during my work assessing families and the reflective supervision model I have developed for practitioners. I highlight the strengths and limitations of the research and explain my contribution to knowledge.

Strengths and Limitations of the Research

One of the main strengths of this research was the benefit it had on extending my own reflective processes and developing my child protection practice. This learning in turn has been used for other social workers' learning by informing my current practice of reflective supervision, and in the teaching and training I provide for child protection social workers as a senior lecturer in social work. Evaluating one's own work is a vital and necessary part of the social work task, as continually improving your practice can lead to better outcomes for children, parents and families. The skill of becoming research minded, being open to other's subjective experiences and thinking about the dynamics in the cases will be taken with me into my own practice and in developing new models of practice, as outlined above. This research developed innovative research methods, which extended knowledge about subjective experience. I demonstrate the use of self as a tool of knowing, and a way of promoting change for families in distress.

There are a number of areas I would have ideally liked to explore further. For example, I am well aware that poverty, class, and structural inequalities played significant roles in affecting parent's ability to meet their child's needs. The research also portrays a rather two dimensional account of fatherhoods, when in fact I had a lot to do with them in the course of my work and I am very interested in supporting fathers to look after their children. The research does not do this area sufficient justice.

In terms of the research design being an insider and having a relationship with the families, social workers and organisation meant that I had access to understandings that

perhaps an outside researcher would not be able to access. It is clear from the interviews that social workers share rich, deep and insightful understandings with me. However, semi-structured interviewing as a way of exploring unconscious factors was perhaps a limited way of accessing this type of knowledge. Being an insider meant that it was also difficult to taking up a researcher role, being open to seeing things from a different perspective. Despite this I was often surprised by what I learnt and do believe that in the end I became the researcher open to new understandings.

Unfortunately one of the main gaps in this research study was the lack of voice from the parent, father, mother or child which would have presented their subjective experiences more convincingly. I did have a certain amount of information from my case notes and parenting assessments which brought the family into the research. However, I am acutely aware that my perceptions of their experiences were obtained in a rather constrained situation where I was in a power relation with them and where the information they provided was in the context of a parenting assessment. Their subjective experiences of the decision making, obtained in a more neutral way would have added vital understanding to the rather limited picture that I have obtained. Another limitation was that a number of the social workers had left by the time I started the research. Therefore, an understanding of the decisions about some children, particularly the ones who were able to remain at home was in part missing.

I argue that any family who falls into this complex category of child protection work usually where the case has become 'stuck' in the system for a number of years the family requires two social workers, one for the child and one for the parent. Then they can come together in a child guidance model, reflect on the identifications and attain a third position on the family's problems.

Conclusions and Recommendations - Contribution to Knowledge

Between the conception
And the creation
Between the emotion
And the response
Falls the Shadow

Life is very long (The Hollow Men, T.S. Eliot)

Eliot uses the metaphor of the fall of the shadow to effectively communicate a certain idea about the bleakness of human existence. He is not so good at communicating the joy, love and liveliness that life can bring and he sometimes irritates me with his

arrogant, superior dryness. However, this quote seems to capture a problem in relating to the world with a liveliness, which I am trying to describe in the following research. This research is primarily about the crippling nature of early emotional deprivation. The quote reminds me of Christopher Bollas's idea of the shadow of the mother, whereby a shadow falls on the ego shaping the mind's prototype of how it experiences its objects. This is the prototype relationship for how all other relationships are experienced or are developed. The research explores the central importance of projective processes particularly projective identification. It describes the ways lives can be destroyed or become overshadowed by haunting internal objects, coloured by experiences of parental failure. When the mind is overshadowed by early traumas, abuse and neglect these shadows fall down the generations, tragically haunting and destroying the capacity for liveliness, joy and freedom from limiting identities.

It is my view that this research has gone some way in proving the viability of the psychoanalytic frame to explain the emotional impact of the work on the worker and the implication this has on decision making. The main contribution to knowledge is in the arena of practice. I have developed a model of parenting assessment and reflective supervision in which to identify complex cases, and which will help to improve outcomes for children. A future task is to develop a model of family support which can contain the problems these complex cases give rise to. There would be three elements to family support;

- 1) **Prevention;** which would include interventions along the lines of the Morning Lane Associates model for relationship problems between the parents (See Appendix II). This would be brief solution focussed therapy aimed at parents who want to stay together, and where domestic violence was just beginning to be an issue.
- 2) **Direct Work;** Working therapeutically where both the parent and child has a dedicated worker, who come together. This would centre around work with the parents as a couple whilst keeping the needs of the child as the central focus. It would focus on improving the relationships in the family. This service would work with families in their home weekly for 6 months up to a year.
- 3) **Recovery work;** There would be a service which would offer containment to mothers and fathers after children are removed. This would be ongoing support to the parents. This could be alongside therapeutic group work offered to women who have lost their children. This would take place weekly over a year.

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Glossary

I mainly use Bower's definitions of some of these terms as she has done the work of describing them for social work students in a simple, none jargonistic way (Bower, lecture notes 2005). I combine and extend her definitions with psychoanalytic theory taken from Freud, Britton, (1989 and 1992), Steiner (1989) and Bion (1967);

Transference: This describes the way in which past relationships and experiences colour the way we see and experience others in the present. This process occurs in all contacts between clients and workers. As a result of transference, we may be seen and experienced in ways which are alien to our own experiences of ourselves. e.g. as abusive or cruel and indifferent. Becoming aware of this process can help us understand how our clients experience us and give important clues about their significant relationships (Bower, 2012).

Countertransference: These are the feelings evoked in the worker as a result of contact with the client. Although these may be a result of the client's projections they may resonate with feelings of our own. A common counter-transference experience in working with families is for the worker to feel in the child's position E.g. angry, helpless, frightened etc (Bower, 2012).

Projective identification: This is a development by Klein of Freud's concept of projection. It is a phantasy that part of the self or an experience can be split off and located in someone else. This affects our perceptions of the other person and can have a real impact on the mind or behaviour of the other person. Very often, projective identification is used to rid ourselves of aspects of ourselves we do not like. Within families this can lead to scapegoating. In the wider society it is often an aspect of racism (Bower, 2012).

Ways of Managing Anxiety - Kleinian Theory

Klein developed the concept of two developmental 'positions'. This differs from Freud's stages (oral, anal etc). The idea of stages refers to a linear development, whereas the concept of 'positions' implies that we all oscillate between the two states of mind throughout our lives.

The Kleinian framework is useful for this thesis as it describes a set of common concepts about how the unconscious works and has a relational and emotional effect on those around. It describes and explains the kind of strong emotional disturbances which social workers face in their work. An explanation of how emotional processes can be transferred and can affect our judgement can free us up from acting without thinking on

these unconscious dynamics. If we can understand the family's communications on a deeper level we may be able to provide them with the right kind of therapeutic support.

The paranoid/schizoid position: The baby is assailed by powerful primitive anxieties. It is totally dependent on the care of the mother to cope. The term 'paranoid-schizoid position' describes a primitive or early mental state in which the self feels disintegrated. It refers to a constellation of anxieties, defences and internal and external object relations that Klein considers to be characteristic of the earliest months of an infant's life that continues to varying degrees throughout life. The chief characteristic of the paranoid-schizoid position is the splitting of both self and object into good and bad, with at first little or no integration between them (Bower, 2012).

Depressive position: The 'depressive position' is a mental constellation that follows the paranoid-schizoid position in the infant's development and is understood to begin in the second six months of life. The baby, gaining in physical and emotional maturity, begins to integrate its fragmented perceptions of its parent and has a more integrated sense of self. Bringing together conflicted feelings of love and hate, realising the hated person and the loved person are one and the same leads to the most anguished sense of guilt and, in time, a wish to repair (reparation). It is repeatedly revisited and refined throughout early childhood, and intermittently throughout life (Bower, 2012).

Reparation: Reparation is inextricably linked to the depressive position, and derives from a love and respect for another person separate from oneself. It is the attempt to repair the damage that is believed to have occurred in phantasy (Melanie Klein Trust).

Ways of Containing Anxiety - Bion's Theory of Thinking

Containment: a concept developed by Bion (1967). The model for this is the way the mother helps her baby cope with difficult emotions. These emotions are projected into the mother (container) who processes them in her own mind and returns them in a more manageable form to the baby (contained). Over time the baby internalises the mother's capacity for containment. In social work terms it is the capacity to be emotionally receptive to client's feelings and to reflect on them before making decisions about action (Bower, 2012).

Reverie: Related to the above process of containment this is the state of mind of the mother in relation to her baby's communications. It is the idea that the mother has the capacity to take in the baby's communications, think about what the baby is communicating in a way that makes the baby feel understood. This allays the baby's fears and anxieties and is likened to the process of digestion. Thought is developed in a

process of projection and introjection between mother and baby. However, Bion also thought that the baby necessarily required to feel some level of frustration as they developed their own internal capacities in order to develop thinking.

Introjection: This is the process whereby the baby takes in their mother's capacity for thinking, developing their own embryonic mind in response to the processes of containment. The baby will eventually internalise (introject) a capacity for thought.

Nameless Dread/annihilation: Babies experience their emotions very intensely, to the point where they fear for their survival. Physical discomforts such as wind or hunger produce terror and a fear of annihilation. You only have to be in a room with a crying baby for a short period of time to experience the intensity of this fear and distress, as a baby's cry can be unbearable. In instances where there is a failure of containment the baby has no way of mitigating these terrifying experiences with enough good experiences of relief. A resultant state of mind can be 'We can be thrown into this unbearable state of mind Bion likened to 'nameless dread.'

Other Useful Psychoanalytic Theory and Concepts

Turning a Blind Eye

Steiner describes the dynamics of 'turning a blind eye' evocatively in his retelling of the story of King Oedipus (1985). Steiner describes how Oedipus both knew and did not know that he had killed his father and married his mother, disavowing this dangerous knowledge. He insists that there was a deliberate turning of a blind eye to these transgressions, by pointing out the evidence of his disfigured foot, which was wounded as an infant left to die by being tethered to the ground. He had been sent to die by his parents who had heard the premonition that he would kill his father. Once he discovers his transgressions he is blinded as a symbolic punishment for his failure to see.

The Third Position: Britton (1989, 1992, and 2005) offers a way of thinking about the internal world of individuals, couples and the position of the child, with his idea about 'the third position,' a concept linked to emotional development (1989). Britton argues that the depressive position and Oedipus complex are 'inextricably entwined' and 'we resolve the Oedipus complex by working through the depressive position and the depressive position by working through the Oedipus complex' (1992). Our capacity to tolerate reality is dependent on an ability to come to terms with and tolerate the deprivations resulting from the Oedipal dynamic, i.e. the exclusion of the child from the 'primal scene and an exclusive relationship with the mother'. Problems in this

developmental achievement arise out of an early parental failure of containment (Bower, 2012). ⁶

Dynamics or psychodynamics: I use these terms interchangeably throughout the thesis. They are not technical terms for psychoanalytic concepts but describe a general set of defence mechanisms which could include splitting, turning a blind eye, countertransference, dissociation, projection or projective identification. The term usually describes an emotional exchange or pressure emanating from internal defences of the individual. These defences then become externalised through projection and have an influence on the external system, such as influencing the social worker, professional system or inter-professional system. I link psychodynamics to interpersonal interactions where one subjectivity acts on another's subjectivity.

⁶ Bower, lecture handout 2012 and Melanie Klein Trust (<http://www.melanie-klein-trust.org.uk/theory>). Also see Hinshelwood (1994) for a fuller description of Kleinian theory. See Frosh (1999) for a discussions about the politics of psychoanalysis and a critique of object relations theory.

Appendix I - Parenting Assessment Model

This research examined the outcomes for the children I had been involved with during my work as an independent social worker. So it is important to explain and describe the basis of parenting assessments, in order that we can understand what it was that I was trying to do with each family. The parenting assessment model was the same across all of the cases, conducted over the same timeframe and explored the same areas of family functioning in each case.

Prior to becoming an independent social worker I worked in a specialist multidisciplinary family centre (The Munroe Young Family Centre). There, I assessed families where child abuse was suspected. The team consisted of adult psychiatrists, child psychotherapists and adult psychologists alongside social workers and family therapists. The work was informed by attachment theory and psychoanalytic theory. The centre's practice used the principles of infant observation to explore the child's internal world and their relationships. These cases were usually already in the court arena and we acted as expert witnesses in care proceedings. It was a highly regarded assessment unit.

On becoming an independent social worker, I transferred the knowledge and skills learned in this position to create a comprehensive model of parenting assessment, which took a far reaching look at the situation of the child and family. This involved visiting the parents at home on a weekly basis over an 8 week period. I usually visited on the same day and same time each week to promote reliability and offer containment in order to see how the parents responded to support. This allowed me to: Observe the child and parent's interactions and the parenting in the home; Talk to the child alone; Talk to the parent alone and gain their history of being parented; Interview the social worker for a history of the case; Review cases files and historical documents; And talk to other professionals. Sometimes cases involved Grandparents and on one occasion a Great Grandmother, providing me with an unique opportunity to assess a family over 4 generations.

If children were already in foster care or kinship care I would visit the child in their foster care home and talk to the adults looking after them about their emotional development. I would also talk to the child in their foster care placement and make observations about their relationships with the carer. If the child was in care I would observe the contact with the parents and child in a contact centre over a number of weeks. The timeframe was important as I used it to assess whether there were any changes in the parent's insight, or in their parenting, over a certain period. This provided

the parent with the opportunity to demonstrate change within a supportive relationship, with an interested professional. It also allowed for the more hidden problems in the families to emerge, such as addiction, sexual abuse, aggression, domestic violence or physical abuse. This durational approach provided me with an insight into the emotional harm the child was or was likely to suffer. Unusually, many of the assessments involved the fathers as well as the mothers, as separate individuals who were wishing to care for the children in their own right. This was unusual, as Swann (2015) found that fathers were often absent from social work assessments (Centre for Social Work Practice seminar, 2015).

The model was built on the Department of Health Framework for the Assessment of Children in Need and their Families (2000). This model particularly looks at environmental factors, child development and parenting capacity. The protection of children is seen as a continuing process not a single event, placing family support at the heart of practice. I developed a way of assessing significant harm, or the likelihood of significant harm, attributed to the parent (Section 47, Children Act 1989). It would be heavily informed by chronology of the concerns in the history of the case, highlighting: Patterns of abuse; The parent's ability to change; Their engagement with services and support; The parent's insight into concerns and the child's needs; And their ability to protect. The assessment process was based on observations of the interactions between the parent and child, but also the quality of their relationships. I placed a heavy emphasis on the child's emotional needs not just their physical needs.

This model was underpinned by Bion's theory of 'emotional containment' and Winnicott's 'holding environment' whereby the worker helps the parent to feel held emotionally and thought about, in order for the parent to begin to think about the experiences of their child. It takes into account the fact that many of the parents we work with are extremely deprived emotionally, and have not had good experiences of early care. They are often in need of some sort of help to process anxieties in order to be able to think about the child's needs. It depends heavily on observational skills and watching the interactions between the parent and child. This was additionally informed by infant observation training I undertook at the Tavistock Centre during which I visited a baby and mother weekly at home over 9 months to observe and understand their emotional development.⁷

The observations would then be reflected back to the parent during the home visit or contact in order to open up discussion about the child's needs. Usually, observations centred around the child's play and communications. It was also important to explore

⁷ For an appraisal of the infant observation model and its application to social work practice and research see Brigg's 1992, 1997, 2005, Bick 1968 and Youell 2005.

what the child meant to the parent, as they may have become identified with resentment towards the absent/abusive partner during relationship breakdown, trauma from the parents past, represent a replacement child, or becoming scapegoated and blamed for a family's ills etc. This would allow an assessment of the parent's ability to think about the child or if they were unable to, to identify what the parent's preoccupations were. Parents preoccupations were usually informed by anxiety related to unemployment, poverty, relationship breakdown, alongside thoughts and feelings related to past trauma and abuse. The model also drew from the principles of Fraiberg et al's 'Ghosts in the Nursery' (1975).

Recommendations were usually about the need for the child's removal from their family of origin, or if the child was already in care the desirability of their return home. Many of the recommendations I made involved adoption or alternative care outside of the family. This was due to the particularly intransigent, chronic and serious nature of the concerns and the harm the children were suffering over a long period of time. Recommendations would also highlight the type of support the parent needed in order to change, although early on I was more concerned about the child's needs. As I have already described, the clinical supervision I engaged with helped me to develop recommendations for what kind of support the parent might need, in order to prevent the concerns resurfacing and requiring intervention repetitiously. Unfortunately at this point in history, a climate of austerity and cuts meant services to parents were dwindling rather than being developed.

I explored the parent's history with them, including their experiences of childhood and being parented. I would do this by undertaking Genograms, getting alongside them to think about their past. This was often a process of discovery for both me and the parents and brought us closer together by promoting a shared understanding of the difficult factors in their childhood. Sometimes patterns would be revealed and links would be made with current problems, such as addiction behaviour, domestic violence and the intergenerational nature of abuse.

Undertaking Genograms usually revealed that the parent had suffered abuse, trauma or emotional deprivation in their own childhood. This helped me to have an empathetic view of the parent's situation rather than a blaming one, and to see the underlying tragedy of the family situation. Crucially, making the parent's suffering explicit allowed me to be more focussed on the child's needs and not so wrapped up in the parent's needs, as I could separate the problems out and understand what was at stake for the child if there was no change. The history somehow provided a triangulating effect, where I could achieve a 'third position' (Britton, 1989). I could acknowledge the parent's suffering in the past at the same time as identifying the child's suffering in the

present and assess whether the parent was capable of change based on their insight into the concerns and motivation to change.

Appendix II : Description of Support Services

FDAC - Family Drug and Alcohol Courts

A partnership between the Coram Foundation and the Tavistock and Portman NHS, which has been replicated nationally. This is a court system which aims to intervene in families where there are alcohol and drug issues. The judges in care proceedings are highly skilled in therapeutic interventions with the parents and intervene with the parents directly. Parents with addiction problems whose children are at risk, are offered a range of support by different professionals and lay persons in order to change their addictive behaviour. There are tight timescales for change that reflect the child's developmental needs. Research has proven that more families stay together and more parents remain off alcohol or drugs as a result of the interventions.

(<http://www.brunel.ac.uk/chls/clinical-sciences/research/ccyr/research-projects/fdac>)

PAUSE

This project founded in Hackney but being rolled out nationally, helps women who are at risk of having children repeatedly removed through care proceedings. It aims to intervene therapeutically with women at risk of repeat removals and the trauma and loss that arises from those losses. Helps build self esteem through accessing health services, engaging women in activities, providing practical help, alongside working therapeutically with women suffering grief and loss. They also expect women to use long term contraception. They are increasingly aiming to work preventatively with women rather than reactively. There is research by Broadhurst et al (2015) about the hidden problem of repeat removals and it is becoming a major concern given the financial and emotional cost of these repeated court proceedings.

Morning Lane Associates

This is a model of practice which uses social workers who have been trained in family systemic therapy. Workers who operate in the children services teams act as consultants. They offer specialist advice to social workers in cases where domestic violence is just becoming an issue. They also offer direct work to families where problems have become more intractable.

<http://www.morninglane.org>

Appendix III: Letter of Consent from the Local Authority

Anna Harvey

7th January 2009

Dear Anna

Re: Research Consent

Please find attached the written details concerning your research, as discussed and agreed with ***, Corporate Director, on 22nd May 2008. I am pleased to confirm consent for you to use data collected about *** children in need and looked after between March 2006 and March 2008, subject to the stated safeguards concerning confidentiality.

The attached details will need to be amended slightly since the proposed timescales have slipped given the later start date. In order for us to clarify these details I have asked

***, Business Administrator to contact you to agree a mutually convenient date and time. It would also be helpful to schedule in our subsequent three monthly reviews at the same time before our diaries get booked up for the rest of the year.

Thank you for confirming receipt of our financial contribution to your doctorate course at the Tavistock and Portman NHS Trust/University of East London (UEL).

I trust that this consent letter and attached signed contract is adequate for your purposes. However, if you, or the UEL Ethic's Committee have any further queries please do not hesitate to contact me directly, or speak with Julie Parker if I am unavailable.

Yours sincerely

***** Name has been removed to protect confidentiality but the original letter is available on request.

Data Protection Act 1998 Service Users of this department have the right of access to all information held about them.

If you do not wish your letter to be seen by a Service User please mark it "RESTRICTED ACCESS" and also indicate

Appendix IV: Letter Requesting Consent for Interviews from Social Workers

Dear (name of Social Worker),

You may remember that I was involved in an assessment regarding a family called (name of family) who you were working with in (date). I am writing to ask whether you would agree to meet with me again for a one off visit at your office so that I can gain an update on the child's current circumstances and also to gain your views on the decisions which have been made in relation to the child and their Care Plans.

The information will be used as part of the research study I am currently undertaking into the factors which inform the Local Authority's decision making and care planning. It will also be part of an evaluation into the work I have undertaken as an Independent Social Worker to improve the assessment process and my practice. Therefore, I would appreciate your perceptions and experience of the assessment process.

This study will lead to my professional advancement, as I am currently on a Professional Doctorate course at the Tavistock and Portman NHS Clinic/University of East London.

This study is in collaboration with *** Social Services and will hopefully inform Social Worker's future training and the improvement of services in **** Children's Services. It has been authorised by senior management.

If you wish to take part in this study please tick the box below and return this form in the stamped addressed envelope provided;

Yes I agree to take part in this study

☐

No I do not wish to take part in this study

☐

Alternatively, if you require any further information about this study and wish to discuss the details further, please contact me on 07974667154 or annaharvey9@talktalk.net.

The information you provide will be dealt with the upmost confidentiality and will not be passed on to any person without your written consent. I will make all the information you provide anonymous, removing any names or places that may identify the participants. Information you provide will not be shared with managers, unless there is an immediate risk to the Local Authority or a child. Information will be analysed as themes only so that no Social Worker is identified in the study. This general, thematic information will then be shared with senior managers to look at the practice and training needs of Social Workers and the needs of families in the *** area.

You are in no way obliged to volunteer if there is any reason, which you are under no obligation to divulge, as to why you should not participate in the programme. You may withdraw from the programme at any time, without disadvantage to yourselves and without being obliged to give any reason.

Yours sincerely

Anna Harvey

Independent Social Worker

Signed by (name of Social Worker)

Dated

Appendix V: Letter for Ethics Committee Approval



Stephen Briggs
Tavistock Centre

ETH/12/16
9 February 2017

Dear Stephen,

Application to the Research Ethics Committee: A social work of the emotional factors affecting decision making and the process of care planning in a Local Authority for looked after children and children at risk of coming into care. (A Harvey).

I advise that Members of the Research Ethics Committee have now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Simiso Jubane', is located below the 'Yours sincerely' text.

Simiso Jubane
Admission and Ethics Officer
s.jubane@uel.ac.uk
02082232976

Research Ethics Committee: ETH/12/16

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed:.....Date:

Please Print Name:

Appendix VI: Further Demographic Information About the Cases

Gender and ages of children

I undertook 17 parenting assessments for the Local Authority between the years 2006 – 2008. This involved 17 families, including 31 children;

18 girls – 58%

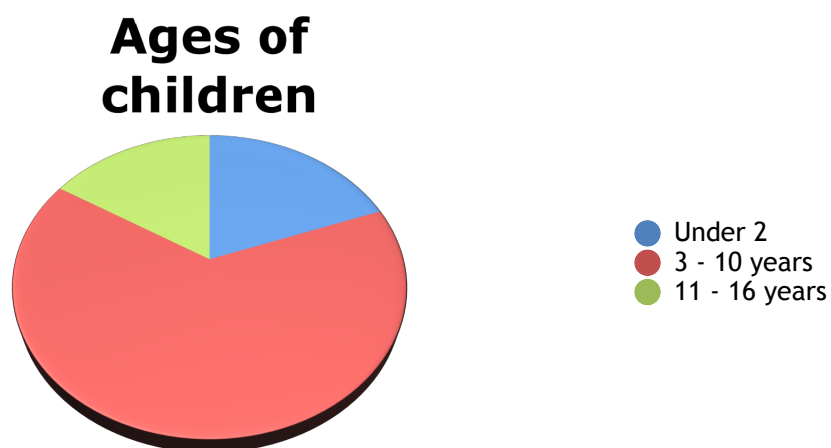
12 boys – 39%

1 unborn baby – 3%

6 children were small infants – 19.5% (5 children were under 1 year old),

20 children were aged between 3 and 10 years old - 64.5%

5 children were aged between 11 and 16 years old – 16%



Therefore girls were more represented than boys.

The majority of children were in the age range 3 – 10 years old with a relatively high proportion in their infancy.

Ethnicity

12 children were of White UK origin (38.5%)

13 were Dual Heritage children (42%)

4 were Indian British (13%)

2 were Black British (6.5%)

Therefore, dual heritage children represented a much higher proportion than white British.

Nature and duration of concerns

Case A - 2 years, emotional harm

Case B - 6 years, emotional harm, domestic violence

Case C - 7 years, physical abuse

Case D - 5 years, domestic violence, sexual abuse and neglect

Case E - 3 years, physical abuse

Case F - 6 months, neglect

Case G - 1 year, emotional abuse and neglect

Case H - 6 years, emotional abuse and neglect

Case I - 2 years, neglect and emotional abuse

Case J - 6 weeks, neglect

Case K - 4 years, neglect

Case L - 3 years, physical abuse, emotional abuse and domestic violence

Case M - 9 years, neglect and emotional abuse

Case N - 6 years, neglect

Case O - 4 years, neglect

Case P - 10 years, neglect, domestic violence

Case Q - 7 years, neglect

Social worker involvement

SW's stayed throughout most of the case (A, D, E, F, H, I, J, K, L, M)

Multiple social workers (B, C, N, O, P, Q)

General information about placements and outcomes

Children remaining at home

There were 6 cases where the children were living at home at the start of assessment totalling 13 children (42%)

Of these 6 cases – 5 cases required no further action and the cases were subsequently closed some time after my assessment was completed.

1 of these cases involved Private and Care Proceedings and the children were removed from the mother to live with their respective fathers.

Children remaining in care

There were 8 cases where the children were in short term foster care at the start of the assessment totalling 12 children (38.5%).

Of these 8 cases – 7 cases proceeded to adoption, via care proceedings totalling 8 children (25.5%).

1 child is still in a short term foster care placement after experiencing multiple placement moves (b)

3 further cases involved children being moved to Kinship Care Placements, a total of 5 children.

Surprisingly only 2 children experienced significant multiple placement moves (B and K)

Out of the total cohort of 31 children, 17 were ‘in care’

Children remaining at home

C, E, G, L, O, Q = 12 children

Adoption

A, I, J, K = 5 children

Kinship care

D, F, H, N = 9 children

Foster care

B, P = 6 children (although 3 possibly adopted by now)

Multiple placement break-down

B and K (before adoption)

Parent's relationships

Single Mothers

6 cases involved assessing a mother where there was no partner on the scene at all (A, F, G, I, K, N). This involved 8 children in total. Therefore approximately a third of the cases were single-mothers (35%), a relatively small but significant proportion of the cases.

Couples;

The total number of assessments that included the birth mother and birth father remaining together as a couple was 3 (L, O, Q) = 17.5%. However, out of these 3 cases only one father lived in the same household as the mother; an Indian family (L). Despite living in the same household together they had a very poor relationship and did not want to be together but the pressure to remain together was mainly cultural as they had had an arranged marriage.

The other two couples lived in separate accommodation from each other although they presented as being in a relationship (O and Q). Relationship problems were reported retrospectively in both cases; one resulted in DV (O) and one in a separation (Q).

Separated but both father and mother requiring assessments;

The total number of families which included a mother and father living in separate homes, who presented as being 'separated' and requiring separate assessments was 3 (B, D, P). In a number of the cases where I assessed a mother and father separately, there was more than one father involved in the case as the children had different fathers (D, P). Of the 3 cases where mothers and fathers were separated I assessed 6 fathers in total, in their own right.

Fathers

Total number of families where birth father still in child's life = 9 (B, D, F, H, L, M, O, P, Q). 53%

Total number of assessments which included a step-father living at home = 3 (17.5%).

Total number of families where father figure (birth or step) involved in child's life = 12 (70.5%)

Total number of families where father's whereabouts unknown (or no assessment requested) = 5 (29.5%)

Fathers and father figures featured quite largely in the assessments whether step parent or birth parents (goes against usual thinking fathers are not represented).

Discussion about couple relationships between parents

Separation between the birth parents had occurred in all but one family (L). However, even in the one family where the parents lived together in the same house, the parents hated each other and described a highly conflicted relationship. This was an Indian family, where the mother was very vulnerable, dependent on her husband and spoke very little English (this was an arranged marriage and she had no family or friends in this country).

There were some families where the relationships between parents were ambiguous. In these there were 'on and off' relationships (7 families/41%) or who were not living together but were presenting as a couple (3/17.5%).

Domestic violence

Some of the worst violence occurred when the children were very young infants (9 families = B, C, D, G, I, J, K, M, P = 19 children) (53%/cases or 61% of children)

In discussion with the mothers 9 were able to identify significant abuse in their own childhoods, either through neglect, physical abuse or by witnessing domestic violence between their parents, as very young children (53%)

2 cases involved children being rejected due to relationship difficulties with partners (A, Q)

Violence towards women

It is perhaps not surprising that there was a high level of current or previous violence towards women involved in the parenting assessments by their partners. Out of 17 families violence was or had been a feature of 12 cases. There was also the experience of witnessing violence or being subject to violence in their childhoods;

B,C,D,E,G,I,J,K,L,M,P, Q (controlling) cases involved current or past domestic violence. A (father had been violent towards her as child). Some form of interpersonal violence as children, sexual abuse, neglect, witness to domestic violence, physical abuse.

12 of the cases involved significant domestic violence either occurring in the past and/or continuing the present (B, C, D, E, G, I, J, K, L, M, O, P). This was 70.5% of the cases, a very high proportion indicating that violence was one of the main issues that lead to social services involvement. Evidence of domestic violence was taken from more than one source including social worker's accounts, police reports, or most movingly, verbal accounts by the children during the assessment. 10 of these cases I would describe as having involved extreme violence and/or highly conflicted relationships – where violence is known to have occurred in front of children – (this is only what we know about) (59%). Some of the violence was very extreme and was raised by the children during assessment (5 families = 29.5%).

Social services concerns at beginning of assessment

Most of the cases (14) were subject to the child protection plan primarily for Neglect (A, B, C, D, F, G, H, I, K, M, N, O, P, Q) = 82%

Two cases were not on a CP Plan at all – but both had been in the past (C and H) = 11.5%

One case was on the CP Plan for physical abuse only (E) = 6.5%

Addiction

In 6 cases the mother had an alcohol addiction (I, J, K, M, N, P). Although I suspected that alcohol was a factor in the problems in a further 2 cases (A, D)

In 5 cases the mother had addiction to alcohol and drugs together (1 suspected, 4 confirmed)

In 6 cases the mother was mainly addicted to drugs (4 confirmed – 1 suspected) (b – suspected stimulant use and benzodiazapines, not confirmed – f known crack cocaine and heroin user, g – suspected prescribed prescription addiction not confirmed, i - heroin and crack cocaine and alcohol, k – heroin and alcohol, j – crack cocaine and alcohol)

In 1 case alcohol was a significant problem for the father (M)

In 1 case alcohol and drugs were significant problems for the 2 different fathers (one father was recovered and had sought treatment successfully) (D)

In 3 cases drugs were a serious problem for the father (B – cannabis suspected crack, J – heroin suspected crack and P – cannabis in one father and crack in the other)

Substance misuse, conclusions

SM = A, B, D, F, G, I, J, K, M, N, P = 11 cases (20 children)

SM in mother = A, B, D, F, G, I, J, K, M, N, P

SM in father = B, D, J, M, P

SM and MH combined A, B, G, J

Mental health problems

1 mother diagnosed with emotionally unstable personality disorder (a) by treating psychiatrist

1 mother described as chaotic and emotionally unstable (b) by social work team

1 mother had psychosomatic illnesses which children developed (g) my suspicions – hospitalised for weakness of the limbs

1 mother diagnosed with personality disorder and depression – suicidal and had been hospitalised on a number of occasions –long term CMHT case (h)

1 mother had psychology assessment – serious personality disorder and in and out of reality (j)

1 mother suspected by other professionals to have personality disorder (l) I thought the father had mental health problems in this case

1 father diagnosed as sociopath by psychologist during care proceedings (P)