

**Don't shoot the messenger: an exploration of how professional networks struggle to receive, contain and process painful communications from and about adolescents in the care system**

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## **Abstract**

I aim to explore the conditions that either facilitate or disable effective networking within the complex, transitory professional networks that support 'looked after' adolescents. Drawing on my experience of undertaking specialist mental health assessments, I identify dynamics within multiagency, interdisciplinary systems that influence the extent to which these assessments contribute positively to the care planning process. I discuss how the intrapsychic and psychosocial difficulties of many 'looked after' adolescents are mirrored in their professional support networks. I use a grounded theory approach, underpinned by psychoanalytic theory, to analyse two reflective case studies of 'looked after' adolescents and two focus group interviews with residential care workers and CAMHS clinicians. Through my analysis I identify six interlinked themes with associated sub-themes. Two relate to the challenging 'external worlds' of many children who enter care and also of those professionals who support them. Two relate to the intense emotional pain and turmoil of the 'internal worlds' of these young people and their workers. The final two relate to various ways in which adolescents who have been neglected and abused attempt to numb or distract themselves from their emotional pain; and to defensive barriers erected by professionals to ward off their young clients' unbearable projections. I argue that defences erected by individual workers against the significant emotional disturbance generated through close contact with these troubled and troubling young people may become rigidly entrenched at an organisational level. The intense anxiety generated by the work can trigger requests for specialist assessments in which the needs of adolescents take second place to those of workers. Conversely, when professionals are in less anxious states of mind they may, in order to enhance the quality of the care planning process, seek an expert opinion in recognition of the value of skills differentiation, alternative viewpoints and collaborative working practices.

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## **Abbreviations**

AR: Action Research

ART: Access to Resources Team

AWOL: Absent Without Leave

CAF: Common Assessment Framework

CAMHS: Child and Adolescent Mental Health Services

COREC: Central Office for Research Ethics Committees

CSE: Child Sexual Exploitation

FGC: Family Group Conference

IAT: Inter Agency Team

IRO: Independent Reviewing Officer

LAC: Looked After Child/Children

NEET: Not in Education, Employment or Training

NSF: National Service Framework

Ofsted: Office for Standards in Education, Children's Services and Skills

ONS: Office for National Statistics

PO: Participant Observation

PPO: Police Protection Order

RCW: Residential Care Worker

TA: Thematic Analysis

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I would also like to thank my colleagues who participated in the focus groups.

And finally I would like to thank my family for always being there.

## **Dedication**

To Kerie, Dermot and all the other young people whom for the past thirty-five years have been at the heart of my work.

# Chapter 1. Introducing my research project

## Section 1. What I set out to research

### 1.1 Research aims and questions

While my overall research aim is to explore some of the conditions that either facilitate or disable effective professional networking, I realise that this potentially huge question needs to be grounded, for the purpose of my research project, in a specific context. I have, therefore, chosen to study particular types of professional support networks that I continually encounter, and am invited to join, in the course of my ongoing work. These are the temporary, fluctuating, often complex and almost invariably expanding, professional networks that are generated in order to support and manage young 'looked after' adolescents in crisis. My research material, methodological approach and overall aim all resonate with the definition offered by Hinshelwood and Skogstad of organisational culture as:

...the implicit way people relate to each other, how they perform the activities, and the way they seem to go about achieving particular objectives. Above all, the observer needs to get a sense of the atmosphere of the organisation generally, as well as specifically on the day, and the emotional quality of the interactions observed (2000b, p.22).

I was employed on a part-time basis between 2005 and 2011 as both a clinical social worker and a psychoanalytic child and adolescent psychotherapist in a dual agency, multidisciplinary, Child and Adolescent Mental Health Services (CAMHS) led team that I have called the Inter Agency Team (IAT). One of my responsibilities was to provide regular liaison with and consultancy to the staff team of a voluntary sector adolescent children's home, to which I have given the name 'Norfolk House'. This home is contracted to accept exclusively young people who are the responsibility of the same local authority that employs the social work senior practitioners who work alongside the clinicians in IAT. As part of my overall liaison and consultancy role with Norfolk House, I was frequently asked to undertake combined 'state of mind' and 'mental health needs' assessments of young people placed in Norfolk House who had been informally identified by key workers in their professional support networks as having

significant mental health issues.

The prevailing, though largely untested, assumption within these professional support networks seemed to be that state of mind assessments and other fairly similar types of specialist mental health assessments help to inform young people's care and treatment plans and in this way contribute to positive outcomes. Rather than simply accepting this benign assumption, I have set out in my research to explore, in a more open-ended way, what happens to assessment reports like mine, from initial referral to dissemination through the professional network. My overall aim is to identify and explore factors operating within multiagency and interdisciplinary systems that influence the extent to which such assessments can help to achieve desired outcomes for troubled adolescents in the care system.

To help me explore the processes through which those working in professional networks struggle to receive, contain and process the painful communications from and about young people in crisis, I have identified a number of inter-related questions which I want to address, inter alia, in subsequent chapters:

- What triggers requests by workers in social care networks for specialist mental health reports on adolescents in care?
- To what extent, if at all, are the young people's intra-psychoic and psychosocial difficulties, especially those germane to adolescence, as well as the family dynamics stirred up by the adolescent process, mirrored in their professional support networks?
- Whose needs are being met by these assessments and in what ways?
- What do referrers and providers understand by various common types of mental health assessment reports and what do they expect useful reports to contain?
- Do the ways in which reports are used and the purposes they serve vary according to the individual and collective states of mind generated in professional networks?

## **1.2 Initial hypotheses and working assumptions**

In approaching my research questions, I am aware that I bring with me the following initial assumptions and working hypotheses that I need to 'own', in order for them to become available for interrogation and, if not substantiated by my research data and findings, rejected or at least modified:

- A request for a state of mind report relates significantly to the level of anxiety generated in the professional network in relation to a specific young person;
- Such a request may sometimes represent a defensive response by the network. Confronted by potentially overwhelming anxiety and sense of helplessness, workers may turn to an 'expert' who is temporarily placed on a very shaky pinnacle and tasked with finding a quasi-magical solution to an intractable difficulty;
- A request may at times be an invitation (conscious or otherwise) to the 'expert' to take up a 'position', which can exacerbate polarisation and splitting in the professional support network;
- Regarding epistemology, I believe that psychoanalytic theory can be usefully applied not only to the study of intra-psychic but also of inter-personal, social and organisational relationships. (In chapter 2 I discuss a number of key psychoanalytic concepts that inform my theoretical approach.)

## **Section 2. Why I chose this topic**

...research is not an impersonal, external and solely intellectual endeavour, but rather a complex personal and social process...good research is an expression of a need to learn and change, to shift some aspect of oneself (Reason and Marshall, 2001, p. 415).

My interest in group and organisational processes derives from my personal and professional learning and development interests and needs. Complex and challenging professional networks and organisational frameworks are increasingly integral to contemporary social care and mental health clinical practice. I hope that my research into how, why and when professional support

networks for young people in care 'work' will contribute to effective multi-disciplinary and interagency working. I worked for several years in a team comprising both CAMHS clinicians and local authority social workers, which I refer to as IAT (the Inter Agency Team). This team is embedded in the professional networks that provide the context for my research. Our work mainly comprised assessments and short-term interventions with children, young people and families about whom children's services had significant safeguarding and mental health concerns. I found myself becoming increasingly frustrated by what I perceived as the serious limitations inherent in the short-term nature of much of my work, in particular the specialist assessments I was asked to undertake with and for 'looked after' children and adolescents (LAC). At times they appeared to have little impact on the ongoing work of the professional support networks created around these young people. I would like, through my research, to be able to make some meaningful links between my specific role as a CAMHS clinician in IAT and the functioning of the wider interagency, multidisciplinary professional networks. I hope that a developing understanding of the processes involved in professional networks and networking can make a contribution to practical, applied knowledge and also, potentially, to the generation of useful and interesting theory.

## **2.1 Personal context**

I suspect that my family background, with parents of different nationalities, cultures and classes, combined with my peripatetic childhood - my father's work meant that I moved home and school almost every year until finally sent to boarding school in another country - has given me an enduring and ambivalent, rather than negative, sense of being marginal, not quite a full member of any social formation, always anticipating the next move. This attitude may have influenced my decision to study social anthropology at undergraduate and post-graduate levels. According to Shaffir and Stebbins (1991, p.20) "If there is one especially well-suited adjective that describes the social experiences of fieldwork, it is marginality." This may also account in part for my curiosity about how, when and why intrinsically shifting and elusive professional networks work or fail to work.

As a young adult I undertook fieldwork in both Hong Kong and London, before training to be a social worker and much later a psychoanalytic child and adolescent psychotherapist. I remember, during my social work training in the late seventies, being encouraged to read Menzies' (subsequently Menzies Lyth) (1960) paper on 'The functioning of social systems as a defence against anxiety'. Although I had not yet encountered psychoanalytic theory in any depth, I was fascinated by the way she framed the rigid nursing rules and structures that my mother had often referred to in her accounts of what it had been like for her as a student nurse in the 1930s in a large London teaching hospital. During the same training I wrote an extended essay on 'The management of anxiety in a residential setting from a staff perspective', in which I drew on Klein, Menzies Lyth, Miller and Gwynne and other psychoanalytically informed writers whose ideas continue to interest and influence me. My paper was based on a four-week residential placement as a care assistant in a long-term hostel for adults who were still labelled at that time (1977) as 'severely mentally handicapped'. I perceived the attitude and practice of some, though by no means all, of the care workers towards the residents to be disrespectful and bordering on contemptuous. The overall experience caused me intense distress, anger and frustration, as well as a sense of guilt, shame and helplessness. The act of writing the paper helped me to reflect on and process this cocktail of extremely painful emotions.

Although I was not conscious of this at the time, looking back I think that my decision, as a newly qualified social worker, to work in a specialist adolescent team was not arbitrary. Having spent my own adolescence until the age of seventeen in the constrained and tightly boundaried environment of convent boarding schools, I was attracted to my young clients' energy verging on wildness, as well as by their capacity for rapid change and development. "Characterised by action rather than reflection, adolescence touches the adolescent in all of us and revives some of the out of control feelings we all lived through both as young children and as adolescents" (Alfille-Cook, 2009, p. 59). In my subsequent career as a social work practitioner, practice teacher and manager within an increasingly turbulent professional environment in both the statutory and voluntary sectors, I frequently found myself challenged and

frustrated by what Cooper and Dartington (2004, p.128) frame as a question of “...what is surface and what is depth in the world of modern organizational life?” (In chapter 3 I discuss my use of thematic analysis (TA) and grounded theory, two related methodological approaches, in order to explore some questions relating to surface and depth in interpersonal relationships and contemporary organisational forms.)

## **2.2 Professional context**

For looked-after children, parental responsibility is often in the hands of a complex organization of carers, including field-workers and their managers as well as foster-families and birth parents. We [child psychotherapists] have an obligation to learn to work more effectively with that larger family (Sprince, 2000, p.431).

My longstanding interest in the psycho-dynamics of organisational life has been re-kindled by my experience of struggling to ‘find my feet’ and take up a specific role within a multidisciplinary, dual agency team comprising CAMHS clinicians from several disciplines (psychiatry, psychology, nursing, psychoanalytic child psychotherapy, systemic family therapy and clinical social work) as well as local authority employed social work senior practitioners. I have struggled at times to locate myself meaningfully and appropriately both in this complex team and in several overlapping professional networks. My choice of research topic derives in part from this challenge.

My role in IAT, as a senior clinician working with vulnerable adolescents, threw up several challenges. As a very part-time post holder, I initially felt rather marginalised in relation to the everyday informal as well as the more formal communication flows within the team. This resonated with my valency<sup>11</sup> for remaining at the margins of whichever situation I find myself in. Also the post I held in IAT while carrying out the fieldwork phase of my research was a

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<sup>1</sup> **Valency** describes a person’s particular preferences and related vulnerability deriving from their personality and history. This can lead, not only to the choice of one career option over another, but also characteristic behaviours and the adoption of a specific role and attitude towards clients and/or colleagues. For example, a worker may find herself repeatedly taking up the role of: ‘pal’, ‘tough guy’, observer, rescuer, scapegoat or expert. Gradually, others may expect, even encourage her to always assume the same role. This expectation is a way for the individual and the network to maintain a safe status quo and to minimise the anxiety that comes with uncertainty but it also stymies flexible and creative thinking.

relatively new and necessarily flexible one, within a team which was still in the process of developing, exploring, negotiating and renegotiating its overall role and task within multi-disciplinary and multi-agency professional networks. In such a complex organisational context, roles, functions, boundaries and hierarchies tend to be flexible, overlapping, at times unclear if not contentious, and subject to rapid change. Cooper and Dartington (2004, pp.127-8), in drawing attention to the "...questions about autonomy and dependency and the management of personal, professional, and systemic boundaries" that have emerged in response to the complexity of contemporary organisational formations, note that "None of us fails to register the differences in our experience, but we all struggle to understand fully their meaning" (ibid). (I discuss these aspects of professional networks in chapter 6.)

When I began to liaise with and provide consultancy to the staff at Norfolk House, the home provided a short-term assessment service to adolescents, both male and female, most of whom only entered the care system in their mid teens. When these were planned admissions, the manager was able, before accepting the referral, to discuss the young person's specific needs, difficulties and family circumstances with her/his social worker; and to consider the potential impact on young people already placed at the home. At other times young people were placed at Norfolk House as emergency admissions because their home environment or, less frequently, previous care arrangements had broken down. In either event, placements were limited to three months.

By the time I was ready to commence fieldwork, Norfolk House was undergoing a cultural, as well as task-centered, transition from its original remit. The local authority now wanted it to function as a medium-term (up to eighteen months) residential home for adolescents aged twelve to fifteen, whose complex needs were unlikely to be met in foster care placements. This externally imposed, non-negotiable re-designation of the home's purpose had a significantly deleterious impact, at least in the short term, on staff morale. Most of the residential care workers (RCWs) anticipated major disruptions to both their established ways of working and to their accustomed mode of relating to the young residents, which might be described as a self-protective wariness of becoming attached because the young person would soon be 'moving on'. Their emotional resistance to the

imposed change of function of Norfolk House can also be understood in part as a reaction to a felt criticism, i.e. they perceived the local authority to be implying that the way they had carried out the previous remit of the home had not been 'good enough'. They felt deskilled and their previous work discredited. Some of these extremely painful feelings were brought to, and explored in, my regular staff consultations during the transitional period. Hinshelwood (1998, pp. 22-23) comments on how unconscious processes may at times "...reduce the individual to less mature levels of functioning, a sort of forced immaturity, and a hard-to-grasp experience of being de-skilled." He notes also that an organisation can deteriorate into "a disturbed service". (I explore these types of process in subsequent chapters.) One consequence of the home's changed remit was that the adolescents placed in Norfolk House tended to remain there significantly longer than previously. I had, therefore, increased opportunities to follow up my assessment reports and to work with the professional networks in relation to my recommendations for addressing the young people's mental health needs. I was occasionally able, when requested by children's services and agreed with the young person, to continue working directly with her or him, after my initial assessment had been completed.

### **2.3 Organisational, cultural, political and socio-economic context**

In the wider work context, the increasing complexity and volatility of organisational forms, spurred on by legislative injunctions to find 'joined up' ways of working has generated a proliferation of multidisciplinary, interagency networks.<sup>22</sup>

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<sup>2</sup> The Children Act 1989, (Section 27); and Children Act 2004, (Sections: 10,11,13) require local authorities to collaborate closely with their 'relevant partners' in both the statutory and voluntary sectors to provide a coordinated response to safeguarding and promoting the welfare of children. These partners include health, police, education and housing. Section 10 of the 2004 Children Act specifically names, "any Local Health Board, Special Health Authority, Primary Care Trust, National Health Service Trust or NHS Foundation Trust." 'Every Child Matters' (2003); the Common Assessment Framework (CAF) (2004); the National Service Framework for Children, Young People and Maternity Services NSF, (2004); 'Care Matters: Time for Change' (2007); 'Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children' (2013); and the Safeguarding Children Boards all stress multi-agency, multi-disciplinary work. Part 9. of the NSF relates specifically to child and adolescent mental health and aspires to improve capacity, inter-agency working, early intervention and effective provision; while the 2007 White Paper 'Care Matters: Time for Change' comments that, "...lack of understanding of the respective roles, duties, responsibilities and organisation of the different agencies and professionals and of their different language may

The increasingly top down emphasis on multi-disciplinary working in health and social care, which is integral to this general trend towards greater organisational complexity, is to some extent a response to the anxiety generated by successive, widely discussed child abuse revelations and resultant child protection enquiries. As Walker, however, points out:

These structural changes will...fail to enable the more difficult changes in culture between previously disparate services. Trying to meld the knowledge and value bases of education, social work and health will take much longer as staff get to grips with the implications of the deceptively easy rhetoric of collaborative and integrated working (2005, p. 237).

A related contemporary phenomenon is the preoccupation with risk avoidance. The demands on professionals to 'get it right' and to come up with solutions are clamorous. Dartington (2010, p.4) proposes that the task facing health and social care has become "...in a societal sense, too difficult, too much associated with failure". The combination of increasing complexity and a punitively risk adverse attitude towards failure, instead of encouraging genuine collaboration within multiagency networks may foster:

...a pervasive underlying dynamic in health and social welfare systems providing services to vulnerable people of fragmentation between these health and social services...replicated within and between different health and social welfare agencies across public, private, and voluntary sectors in a mixed economy of care (Dartington, 2010, p. 4).

It is an extremely skilled task to provide effective substitute professional care for children and young people who are distressed, confused and enraged by the absence of ordinary, good enough, informal family care. The challenge is exacerbated rather than alleviated by a wider societal culture that tends to blame both the victims - the young people themselves - and also those working with them for failing to find 'solutions' to intractable difficulties.

Child and adolescent psychotherapy and social work, my two professions, are both inevitably influenced by prevailing political ideas, social attitudes and economic environment. My research project needs, therefore, to take into account all these environmental factors, the most intrusive of which is perhaps

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lead to poor communication, misunderstandings and frustrations" (2007, p.25). Service responses to these legal requirements have included: the amalgamation of education and social services (there is now a requirement for all local authorities to have Directors of Children's Services); the creation of multi-disciplinary, inter-agency teams; shared data bases; and policy guidance to enable easier joint budgeting between agencies.

the current increasingly restrictive economic climate operating at both national and local levels. This, in turn, has a powerfully negative impact on the capacity of workers to feel hopeful about their professional security and prospects as they confront shrinking resources and ensuing job insecurity.

### **Section 3. How I undertook the research**

In undertaking this qualitative research project I use a basically inductive methodology, a type of latent transactional analysis or grounded theory, in order to explore the various states of mind encountered and engendered within the professional networks through the process of undertaking and disseminating my assessments. Starting from the psychoanalytic theoretical position that unconscious factors have a significant impact on organisational functioning, my research attempts to engage in a type of theory building that remains close to practice. I believe that a developing capacity to engage in critical reflection of my own practice has helped me to 'survive and thrive' in the complex and challenging work environment providing the context for my research. My reflections are underpinned significantly by psychoanalytic observation skills and theories that, in my experience, offer creative ways to think about what is being observed. My fieldwork experience, undertaken within a classic 'participant observation' (PO) model, gave me some familiarity with PO as a research methodology. Later in my career as a social worker and a child psychotherapist, I undertook several psychoanalytic infant and young child observations. I also try to ensure, through attempting "...to explore and deal with the relationship between the researcher and the object of research" (Coghlan and Brannick, 2005, p.5), that my practice and current research study demonstrate reflexivity. (In chapter 3 I discuss reflective practice and research, as well as similarities and differences in approach between PO and psychoanalytic observations and reflexivity.)

I take a 'real time' approach to my research and make use of a naturalistic, emergent design to enable me to analyse unfolding psychosocial processes and interpersonal dynamics. I focus on the inevitable tensions and conflicting perceptions generated as workers attempt to respond adequately and

appropriately to the overwhelming difficulties and needs of young people in the care system at a critical developmental stage, early adolescence. I try to keep in mind three basic questions related to my lived experience at work:

- What is happening at any given time?
- How can I make sense of this?
- What might I learn from this specific experience that could be helpful in a wider context?

Since the research setting, i.e. my own practice environment, is by definition naturalistic rather than experimental, the behaviour I encounter and attempt to understand is inevitably embedded in systems characterised by multiple cause and effect. Also, events unfolding in real time are unpredictable. Stokoe (2003, p.86) argues that “Healthy growth throughout life depends upon our ability to tolerate the frustration of not knowing what is happening to us long enough to allow a new idea...to reveal itself.” I am sometimes baffled or confused by what is going on, not only within myself and between me and my young clients, but also in my interactions with professional colleagues. I hope and believe that tolerating this sense of frustration encourages me to reflect on what might be happening at such times:

One exists most of the time in a state of partially self-imposed ignorance which may feel profound, frightening and painful. One needs faith that there is light at the end of the tunnel, even when one does not have much hope (Menzies Lyth, 1989b, p.32).

My research material derives from two main sources. The first source, on which I draw extensively in chapters 4 and 5, comprises reflective case studies of the various stages involved in carrying out and disseminating state of mind/mental health needs assessments<sup>3</sup> with and about two young adolescents placed at

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<sup>3</sup> In principle, assessments include all or most of the following eleven stages although in practice stages may be skipped for a variety of reasons:

- Receiving a referral about a young adolescent placed at Norfolk House;
- Organising an IAT planning meeting with the referrers, comprising both the allocated social worker and the management of Norfolk House;
- Agreeing and confirming in writing the details of the intervention;
- Familiarising myself with available written information, including family background, developmental history and previous assessments;
- Planning and timetabling the assessment process;
- Holding at least one, preferably three, sessions with the young person;
- Writing up the assessment report and recommendations;
- Inviting the young person to a follow-up meeting to discuss my report;
- Having follow up consultations by phone and/or in person with the referrers;
- Participating in subsequent professional network meetings;

Norfolk House, to whom I give the names Kerie and Dermot. My second data source comprises the transcripts of two focus group interviews undertaken with RCWs in Norfolk House and with clinicians from IAT. (I discuss my use of case studies and focus groups in chapter 3.)

## Summary

In this introductory chapter I identify my main research aim, which is to contribute to an understanding of the dynamics in professional support networks. I outline my intention to explore both the relationships between young people in the care system and those working in their support networks; and also the relationships professionals have with each other. This will involve an attempt to analyse how processes are negotiated and transacted, occur and mutate in professional networks. I also discuss my personal and professional reasons for selecting this topic. Finally, I give a brief account of the theoretical and methodological approach I take to my research project.

In the two following chapters I go on to discuss how psychoanalysis provides both a theoretical and a methodological framework for my research. In chapter 4 I introduce the first three of six themes: external words; internal worlds; and minds like minefields, and relate these to my reflective case studies on Kerie and Dermot. In chapter 5 I introduce my final three themes: external worlds revisited; internal worlds revisited; and when thinking becomes unbearable. I then explore the proposition that the same broadly defined themes identified among individual workers can also be discovered at the organisational level in professional support networks. In chapter 6 my analysis focuses on specialist mental health assessments, drawing mainly on material from two focus group discussions with RCWs and CAMHS clinicians respectively. My final chapter reviews my research findings and suggests ways in which they might be applied to practice, policy and research.

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- Continuing to liaise for some time with members of the relevant multiagency professional network in relation to my recommendations.

## **Chapter 2. Theoretical framework**

### **Introduction**

In this chapter I outline my theoretical framework which, although utilising systemic ideas, derives mainly from psychoanalytic modes of interpretation, in particular object relations theory. I investigate the scientific credentials of psychoanalysis and outline the key concepts on which I draw. I then attempt to understand the defences against anxiety thrown up by groups and other organisational formations. Finally I explore how professional support networks often exhibit borderline characteristics that inhibit their capacity to carry out their designated tasks.

### **Section 1. Psychoanalytic theory**

As outlined in chapter 1 my overall research aim is to bring about a greater understanding of some processes and dynamics operating in professional support networks. In order to do so, I engage in a form of inductive theory building within a largely psychoanalytic paradigm. My intention is not to try to prove or disprove specific hypotheses and/or to establish unilinear causal relationships, but instead to identify meaningful, non-linear, complex and sometimes multiple connections between phenomena.

#### **1.1 Is psychoanalysis scientific?**

Kuhn (1996, p.10) distinguishes between 'revolutionary' and 'normal' science, the latter being "...research firmly based upon one or more past scientific achievements". He argues that in 'normal' science research is undertaken incrementally within a paradigm. When the evidence does not fit the paradigm, 'revolutionary' science interrupts 'normal' science and a new over-arching theory, or paradigm, emerges to explain the misfit: "The new idea 'explodes' the formulation designed to express it" (Bion, 1970, p.80). However:

After we have become familiar with the new idea...after it has become part of our general stock of theoretical concepts, our expectations are brought more into balance with its actual uses, and ...thinkers settle down after a while to the problems the idea has really generated (Geertz, 2000, pp.3-4).

While Freud's ideas initially created a paradigm shift, subsequent psychoanalytic enquiry, of which my research is an example, may be conceptualised as 'normal' science taking place within the psychoanalytic paradigm: "A view of the facts is always *a partial view from somewhere*" (Nagel, 1986, cited in O'Shaughnessy, 1994, p.940, italics in original). O'Shaughnessy, while agreeing with Nagel, argues that this view does not necessarily entail a relativist epistemology: "Because there are impediments to attaining objectivity, this does not mean we have none; it means it is hard to attain" (1994, p.943). It is quite possible to accept both the reality of objectivity and also the near impossibility of obtaining it. Knowledge is inevitably partial because it is mediated by personal and professional belief systems and histories and by one's own theoretical frameworks. This position is not dissimilar to Einstein's contention that "It is theory which decides what we can observe" (Einstein, 1916, cited in Campbell *et al.*, 1994, p.7).

## **1.2 'A toolkit of psychoanalytic concepts'** (Obholzer, 1994a, p.11)

In approaching my research I have found a number of psychoanalytic concepts, derived mainly from Kleinian and post-Kleinian object relations theory, of particular relevance. These include: the coexistence of a mutually reinforcing or modifying relationship between an internal and an external world; and also of more or less healthy and more or less destructive aspects of the personality (Bion, 1957). Klein postulates two basic positions: paranoid-schizoid and depressive. The former is associated with denial, splitting and projection while the latter denotes a capacity for greater integration and containment. Projective identification is, according to Klein (1984, p.6), an intra-psychic process whereby a baby phantasies that s/he has split off aspects of her/himself and located them in another person:

It is in phantasy that the infant splits the object and the self, but the effect of this phantasy is a very real one, because it leads to feelings and relations (and later on, thought-processes) being in fact cut off from one

another. Much of the hatred against parts of the self is now directed towards the mother. This leads to a particular form of identification which establishes the prototype of an aggressive object-relation. I suggest for these processes the term 'projective identification' (Klein, 1984, p.8).

Bion (1962a, p.90) emphasises the interpersonal aspects of projective identification. He proposes that unbearable infantile fears are projected into a good breast and then subsequently re-introjected in a more tolerable form, making use of this notion to develop the generative ideas of 'container' and 'contained'. Healthy emotional growth is envisaged as dependent on this dual process of projection into, and subsequently re-introjection from, an emotionally resilient and containing maternal figure. This process, however, requires the birth mother or substitute maternal figure to be able to enter a state of mind, which Bion (1962a, p.36) calls 'reverie':

If the feeding mother cannot allow reverie or if the reverie is allowed but is not associated with love for the child or its father this fact will be communicated to the infant even though incomprehensible to the infant.

Bion (1961) extends the concept of projective identification to include group phenomena. These ideas underpin my understanding of the significant emotional difficulties confronting young people like Kerie and Dermot. I use them to explore the processes through which unbearable feelings may be passed from troubled and troubling adolescents to those who work with them. I am also interested in the dynamics operating between individuals in professional support networks and at the level of the organisational formations themselves.

## **Section 2. Applying psychoanalytic and systemic theory to group and organisational processes**

My research is 'psychosocial' (Hollway, 2008, p.141) in that it is not restricted to individual, intra-psychic or to interpersonal processes. The container-contained relationship and the concepts of projection and projective identification inform my understanding of both the normal and, at times, pathological processes through which those working in social care networks communicate and/or fail to communicate in informal, largely unconscious ways. These processes are

implicitly recognised and given expression in ordinary language, for example the expression to give someone 'a piece of one's mind' when angry with another person; and people 'throwing' accusations at each other. Hollway (2008, p.149) argues for the explanatory value of her research approach, which like my own uses the concept of projective identification. According to her, this "...provides a radical foundation for a psychosocial research epistemology. We learn through identifications with objects. This is at the core of the idea that researchers can use their subjectivity as an instrument of knowing."

Although my research is largely within the psychoanalytic paradigm, I also utilise a number of systemic ideas in order to make sense of my material. There are several family resemblances between the two theoretical orientations. Obholzer (1993, p.7), for example, in describing the process of splitting and projective identification in the paranoid-schizoid position, criticises "...the putting into place of an organisational structure that is counter to the process of debate, dialogue and reason. Instead, there is a 'them and us' situation at every level of institutional understanding." Campbell (2009, p.3) argues from a systemic 'positioning theory' perspective that dialogue is "...the glue that holds different parts of a system in interaction."

A systemic approach to the understanding of groups and organisational forms highlights the interdependence of all those working in the system and ways in which an intervention in one part of the system may impact on other parts of that system. It is, therefore, very relevant to the material under study. Although using different terminology, systemic theory argues, as does psychoanalysis, that the observer/researcher is part of the system. It follows that she will influence the research project from the start, for example, through deciding what is worth studying:

Since no one within an organization can be removed from the feedback loops that connect all the parts of the organization, the process of one person "observing" a problem in another person creates a false dichotomy between the observer and those observed (Campbell *et al.*, 1994, p.13).

## **2.1 Group and organisational defences against anxiety**

...institutions are used by their individual members to reinforce individual mechanisms of defence against anxiety, and in particular against recurrence of the early paranoid and depressive anxieties first described by Melanie Klein (Jaques, 1955, p. 478).

At times of political, economic and societal insecurity and threatened hardship, such as that currently being experienced in the U.K., bureaucratic organisational structures and employment legislation may be inadequate 'containers' for the mounting anxiety generated by an increasingly volatile and insecure work environment. Continuous reorganisations; fixed and short-term contracts; payment by results; enforced job mobility within and between organisations triggered by outsourcing, downsizing, etcetera; and an increasing emphasis on networking all tend to emphasise and prioritise the individual over the group/team/collective.

In spite of the formal structures erected to contain and sustain existing organisational forms, cooperative 'work group' modes of working and thinking are increasingly challenged. An informal 'shadow' culture may emerge which encourages individualism, narcissism, competition and mutual distrust, all of which characterise the paranoid-schizoid position. "Organizations are interpersonal places and so necessarily arouse those more complex emotional constellations that shadow all interpersonal relations: love and hate, envy and gratitude, shame and guilt, contempt and pride" (Armstrong, 2005, p.91). Unconscious, intra-psychic, interpersonal, and even intergroup defences may begin to proliferate to such an extent that the organisation starts to function as a social defence system.

Both Jaques (1955) and Menzies, in her 1960 paper, argue that the social defence system of an organisation helps to determine its structure, culture and mode of functioning.

A social defence system develops over time as the result of collusive interactions and agreement, often unconscious, between members of the organization as to what form it shall take. The socially structured defence mechanisms then tend to become an aspect of external reality with which old and new members of the institution must come to terms (Menzies, 1977, p.11).

In her study of a large London teaching hospital, Menzies (1977, p.38) explores the ways in which work is managed and organised in the institution. She argues that unconscious “primitive psychic defence mechanisms” protect staff from the full impact of the extremely challenging task of working with ill, possibly dying, patients. She hypothesises that human systems, just like individuals and groups, tend to become organised around the task of protecting staff from the psychic pain generated by the work they undertake, rather than around the overt, formal task of the organisation. While this social defence system arises initially in response to individual needs, over time it may rigidify. Such a carapace, described by Bower (2003, p.145) as an ‘exoskeleton’, purports to offer support, but actually suffocates. “When the anxiety level in teams is such that the contained (the anxiety) shatters the container...this gives rise to social, organizational defences that shore up the fragile social care system, acting as pseudo-containers for the work” (Foster, 2002, p.95).

According to this psychoanalytically derived model, when confronted simultaneously by the pressures of their 'external world' work task and the 'internal world' anxieties reactivated by that task, workers may combine at an unconscious level to modify work patterns in ways aimed at minimising their exposure to psychic pain. Like those utilised at the intra-psychic and inter-personal levels, techniques for mastering anxiety in large-scale social situations involve splitting and projection. The defensive system:

...consists, first, in fragmentation of the core problem so that it no longer exists in an integrated and recognizable form consciously and openly among those concerned. Secondly, the fragments are projected onto aspects of the ambience of the job situation, which are then consciously, and honestly, but mistakenly, experienced as the problem about which something needs to be done, usually by someone else.... (Menzies Lyth, 1989b, p.30).

Miller and Gwynne's (1972) study of residential institutions for the physically disabled and chronically sick highlights the almost intractable task implicitly assigned to those organisations that work with and manage, on society's behalf, those who for various reasons become marginalised. They may fail to conform, threaten notions of how people ordinarily live or represent the fragility of life. This task, whether carried out by prisons, hospitals, residential care homes or social services departments, inevitably invokes complex and intensely painful

feelings, including anxiety, guilt, shame, hopelessness and anger, among those to whom this work is entrusted. The defences erected to ward of this emotional onslaught are understandable, probably inevitable and possibly essential. They can also be dysfunctional and toxic, both for service users and workers. (In chapters 4 and 5 I explore the defensive barriers against unbearable emotional pain erected both by LAC and also by the professionals who support them.)

## **2.2 Work group and basic-assumption group mentalities**

As a result of an experiment undertaken while in charge of the training wing of the Northfield Military Psychiatric Hospital during the Second World War, Bion (1961) concludes: firstly that the behaviour of each group member influences and, in turn, is influenced by that of every other member; secondly that the rational working of the group is profoundly affected by the emotions and irrational feelings of its members; and finally that the group potentially learns through experience to achieve increased contact with reality. From these premises, he conceives of two very different and opposed types of group processes or mentalities: 'work group' and 'basic-assumption group'. "Every group, however casual, meets to 'do' something; in this activity, according to the capacities of the individuals, they cooperate... This facet of mental activity in a group I have called the Work Group" (1961, pp.143-144). In stark contrast, when a basic-assumption mentality is temporarily in the ascendancy, group members individually and collectively behave in ways that attempt to meet their unconscious need to minimise anxiety and internal conflict.

Basic assumptions are commonly held, unconscious, 'anti-task' group processes that obstruct and divert work group activity. Because they are both expressions of, and defences against, primitive anxieties generated by the nature of the work task, it follows that the more challenging and anxiety provoking the task, the more vulnerable and prone to basic-assumption group functioning the members of the group become. In work group mentality, members are able to cooperate with one another and to recognise and even to value difference. However, when the group is under the sway of a basic-assumption "...effective work, which involves tolerating frustration, facing reality,

recognizing differences among group members and learning from experience, will be severely impeded” (Stokes, 1994a, p.23).

Because the members of the work group are aware that they need to learn and to develop their skills, both personal and interpersonal, and the group is in touch with reality, it recognises and welcomes its interdependence on the environment. In so doing, it operates as an open system, (a term discussed later in this chapter) in which its members are continuously communicating, cooperating, modifying and being modified by their contact with external reality, not only through their relations within the group, but also across its boundaries. The basic-assumption group, in contrast, feels omnipotent, self-contained and self-sustaining, with no need to develop or to learn through communication and cooperation. Functioning more or less as a closed system and defensively ignoring external reality, it is at severe risk of stagnation and regression.

Despite their names, the work group and the basic-assumption group are not distinct, but instead involve the same individuals working in two different and opposed group modes. Within basic-assumption group mentality there are three clusters of assumptions about how the group will achieve its aim, cohering respectively around the notions of dependency, pairing and fight/flight. All three clusters, however, use the paranoid-schizoid position defences of splitting and projective identification. Unlike when they are functioning as a work group, members functioning in a basic-assumption mentality lose their individuality, their ability to keep in touch with reality and their belief in any need or capacity to develop through cooperation:

Participation in basic-assumption activity requires no training, experience, or mental development. It is instantaneous, inevitable, and instinctive...basic-assumption activity makes no demands on the individual for a capacity to co-operate but depends on the individual's possession of what I call valency” (Bion, 1961, p.153).

### **2.3 The primary task, the organisation-in-the-mind and organisational states of mind**

The primary task of an organisation can be defined as the task for which it was set up and which it must carry out in order to ensure its survival in relation to the

demands of the external environment. The notion of the primary task was formulated by Miller and Rice (1967) as a response to the question of how an organisation is able to remain in work mode or 'on task', instead of drifting towards 'off-task' or 'anti-task' activities - unconscious defensive responses to which those working in the organisation are attracted in order to avoid the anxiety inherent in undertaking its primary task. Such defensive anti-task activities, undertaken in a basic-assumption state of mind and generated by 'internal world' anxieties about psychological survival, may become increasingly dysfunctional, resulting in escalating anxiety levels among those who make use of them. Obholzer (1991, p.4) observes a tendency among those working with adolescents "...to fall into anti-task ways of working – something that happens as a result of both the workers' and the institution's needs to unconsciously defend themselves against the pain of the work that cannot be contained." (I discuss several anti-task defensive practices in Chapter 5.) I have found it helpful to hold in mind, when trying to understand the behaviour of workers in social care networks, the differentiation made by some commentators including Zagier Roberts (1994a) and Dartington (2010) between three types or aspects of the primary task. These are: firstly the normative task, that is the official task of the organisation; secondly the existential task, approximating to what the members of the organisation believe they are doing; and thirdly the phenomenal task, which is what is actually going on and about which workers in the organisation may have minimal conscious awareness. The complexity generated by the interweaving of these three aspects of what is taking place at any one time contributes substantially to the difficulties noted earlier of distinguishing between surface and depth in organisational life:

Though many things belong to culture, a psychoanalytic view directs attention to those that are unconscious – the unspoken, shared attitudes, unacknowledged anxieties and conflicts as well as the quality of the atmosphere... Despite being unconscious, these aspects are quite dominant (Hinshelwood and Skogstad, 2000a, p.9).

Stokes (1994b, p.121) refers to 'the organization-in-the-mind', a related concept, which he defines as "...the idea of the institution that each individual member carries in his or her mind... Although often partly unconscious, these pictures nevertheless inform and influence the behaviour and feelings of the members." Organisations, the primary task of which is to care for vulnerable and marginalised people, tend to fluctuate between two polarised organisational

states of mind. Both are defensive and dysfunctional manifestations of the paranoid-schizoid position: either an inflated, unrealistic hopefulness; or a crushing sense of hopelessness and helplessness. The depressive position, in contrast, "...accepts more readily that stuff happens, good and bad, during our brief time in the world" (Dartington, 2010, p.47). The latter state of mind, at both individual and organisational levels, recognises and tolerates ambivalence. It also allows for a more realistic and ultimately more compassionate perception of the 'primary task' of those working in social care and health, whether as an individual worker, as a team, as an organisation or as a multiagency network. I propose a working definition of this primary task might be 'to respond respectfully and empathetically to other people's vulnerabilities and dependency needs without needing to deny one's own.'

#### **2.4 Professional networks as borderline organisational forms**

"...a psychic retreat comes to represent a place where respite from anxiety is sought...this is achieved by a greater or lesser divorce from contact with reality" (Steiner 1993a, p.88).

We are all, from time to time, at risk of becoming stuck in some version of a 'psychic retreat' (Rosenfeld, 1971; Meltzer, 1992). This borderline pathological state of mind and mode of functioning, though initially welcomed as an escape from the inevitably arduous and at times painful work associated with ordinary developmental growth, is difficult to exit. Steiner (1987, p.328) conceptualises a defensive borderline state between the depressive and the paranoid-schizoid positions "...where the patient believes he can retreat if either paranoid or depressive anxieties become unbearable." Rustin (2005, p.12) applies this concept to her analysis of why so many professionals failed to respond to the chronic abuse suffered by Victoria Climbié:

Just as the individual patient can persuade himself unconsciously that reality can truly be avoided if he stays put within the narrow confines of his personal psychic retreat, so workers...and the organizations themselves, as represented by their structures and practices, seem to have been convinced that they could escape having to think about their contact with Victoria and her aunt.

Dartington (2010, p.23) extends the application of the concept to work organisations themselves which, he argues, may also have borderline personalities, inhabiting "...an uneasy space between a depressive position of institutional integration, continuity, and dependency and a paranoid-schizoid mentality of win-lose competitiveness, offering total success or annihilating failure, boom and bust." Through their organisational cultures, for example the prevalence of a fight-flight basic assumption, social formations may operate in ways that could be described colloquially as, for example, depressed, manic, suspicious or fearful. One organisation might be authoritarian, another bureaucratic and a third laissez faire. A delinquent organisational culture might even exhibit antisocial and gang like features (Dartington, 2010, p.12).

## **2.5 Applying systems theory to professional networks**

According to Robinson (1979, p.186) "Systems Theory is a way of understanding and explaining that organized complexity known as a system, that set of elements or individuals standing in relationship or interaction." The system is perceived as a whole, which is greater than the sum of its parts. Systems theorists are interested in how information is exchanged and how the constituent components (for example people) interact within and across the evolving system in organised, consistent and largely predictable ways. This focus on a group or organisation in its entirety, rather than on its constituent parts, has parallels with Bion's (1961) theories on groups and also with the ideas of Jaques (1955); Menzies (1960); Bott (1976) and others who adopt and adapt Bion's conceptual framework in their organisational studies. According to Dartington, who worked with some of these researchers at the Tavistock Institute of Human Relations, "A 'systems psychodynamic' view of organisational life conceptualises an organisation as an open system, interacting with its environment" (2010, p.7).

"While the components of a system must "fit", there must also be sufficient difference and diversity among the parts for each to be demarcated and defined in relation to the other" (Campbell *et al.* 1994, p.25). The component parts are both differentiated and mutually dependent. Continuous interaction between

parts, including the exchange of information, is essential to the maintenance and healthy evolution of the system. This information exchange enables the system to be resilient and adaptable, to 'learn from experience' and to evolve. Communication breakdowns and/or rigidity and atrophy can lead in social systems to the types of unhelpful defences described by Jaques (1955) and Menzies (1960). "Such defensive reactions to institutional problems often mean the institution cannot really learn" (Menzies Lyth, 1989b, p.30). Although these defences are adopted at individual and small group levels, they cannot be explained without taking into account and examining the wider organisational context.

As well as maintaining internal communications, any system, unless totally closed, functions in a sophisticated two-way exchange relationship with its environment. Bertalanffy (1968) uses the term 'open system' to describe the way that a system mediates its relationship to its environment by means of a permeable boundary through which it receives inputs and then, having processed them, returns them as outputs. In the same way that a continuous exchange between parts of the system is essential to the health of the system, so also there is a continuous exchange with the environment. If this atrophies, and the system becomes 'closed', it is likely to become increasingly unhealthy. Dangerous, gang-like families, for example, have a tendency to isolate themselves, other than superficially, and to turn in upon themselves (Meltzer, 1976; Bower, 2005; Cooper, 2008). Within an open social system, whether it is a family, professional network or large scale institution, the organised 'whole' comprises individuals whose relationships to each other are of a non trivial nature and whose interactions are complex and non-linear. Most social systems have multiple inputs and outputs as well as a variety of task systems, both internal and across the boundary with the environment. While this continuous interaction is valuable, it is not surprising that, given the complexity of open systems, it also generates competition and, at times, conflict, both within and between systems (Zagier Roberts, 1994a).

After thirteen years of intermittent fieldwork focused on a British psychiatric hospital (referred to in that period as a mental hospital), using a mixed research design of observations and interviews, Bott (1976, p.97) concludes that she:

...had been paying too much attention to what was going on inside the hospital and too little to the hospital's connexions with its environment. Henceforth I began to re-examine what went on inside the hospital in the light of its relationship with the outside society.

Finding that levels of admission and duration of stay in the psychiatric hospital relate directly to changes in the capacity and willingness of family members to provide home care for their temporarily disturbed relatives, she hypothesises the existence of:

...an intrinsic conflict between individual and society which pervades hospital activities and organization...the hospital's divided responsibility leads to conflicts inside the hospital; the ramifications of this conflict are incompletely recognized and there is considerable discord and bafflement among hospital staff...the basic conflict between patient and society concerns sanity and madness and where they are to be located (Bott, 1976, p.98).

She argues that psychiatric hospitals are drawn into performing, on behalf of the wider society, the role of maintaining and concretely enacting a radically defensive split between 'outside', where by definition people must be sane, and 'inside', where mad people are accommodated. Through this manoeuvre, the fear of becoming mad is projected into the institution, which is expected to contain this deep, unspoken anxiety on behalf of society. Contemporary health and social care agencies are allocated similar implicit roles and functions. However, as open systems become increasingly complex, extended, elusive and attenuated, the risk that their conventional containing functions will collapse likewise increases. In chapters 5 and 6 I apply psychoanalytic and systemic ideas outlined in this chapter to the professional support networks in which I work and to the role of a CAMHS clinician working within these networks.

## **Summary**

Those working in professional support networks, just as those for whom they provide services, experience a number of significant anxieties. In the former case these derive significantly, though not exclusively, from the very challenging nature of the work task. In order to defend against these anxieties workers may adopt a variety of defensive strategies. If and when these become entrenched

at an organisational level, service users will almost inevitably receive a significantly less than optimal level of care and attention.

## Chapter 3. Methodology and research design

### Introduction

As well as providing a theoretical framework and a practice, psychoanalysis also offers a research methodology through which discoveries initially made in the consulting room may be generalised to psychosocial phenomena (Rustin, 2003, p.142). While my research project applies psychoanalytic theories to processes taking place outside the consulting room, it involves three crucial aspects of psychoanalytically informed research: observation, recording and interpretation. In this chapter I explore my methodological approach, which involves an orientation towards knowledge acquisition that Bion (1970), borrowing from Keats (1817), describes as 'negative capability', that is the challenge to remain open to experience, holding back expectations and pre-existing convictions. "In so far as I have been able to sustain negative capability...I have indeed spent long periods in sessions and afterwards in a painful state of not knowing at all what is going on" (Menzies Lyth, 1989a, p.4). My overall aim is to achieve within the psychoanalytic paradigm vivid descriptions that facilitate an exploration of the potential meanings inherent in the relationships and processes operating in professional support networks. I aim for depth rather than breadth of analysis. Qualitative research methodology draws on various social sciences and also on the arts and my approach, though largely derived from psychoanalysis, is eclectic. I borrow from social psychology (thematic analysis); sociology (grounded theory); social anthropology (ethnography and participant observation) and a systemic perspective, in order to achieve what I hope is a 'good enough' methodological fit with my research topic. My information sources comprise detailed descriptions of events, relationships and interactions and my research setting is one of naturally occurring situations (Patton, 1980, p.41). My approach is inductive in that I attempt to make sense of what is going on at any particular time without imposing my preexisting expectations, from which starting point I aim to identify emergent patterns and themes. At the same time, I am aware of the extent to which my perceptions of what I observe are framed by psychoanalytic theory. I attempt to remain alert to the inevitable influence of my expectations and assumptions, both theoretical and personal, when interrogating my material.

This interrogation is conducted through applying a type of thematic analysis, a methodological approach to which Braun and Clarke (2006, p.81) give the name, “grounded theory ‘lite’.”

### **0.1 Psychoanalysis as both theory and methodology**

Within any scientific paradigm, the attempt to differentiate between theory and method can be elusive, especially if one rejects the claim that there can be only one scientific method, holding instead, as I do, that different methods are appropriate to different sciences, whether social-behavioural or natural. Since Einstein (1916) wrote about the principle of indeterminism, identifying what amounts to the relativistic nature of the universe, scientific theories tend no longer to seek absolute and ultimate truths in the belief that these can be discovered independently of and uninfluenced by the frame of reference of the observer. Because reality is mediated by belief and perception, the meanings we attribute to phenomena are inevitably influenced by our backgrounds, personal and professional experiences and values. Most contemporary scientific endeavour aims to accumulate approximate truths or ways of understanding phenomena. While scientific theories provide more or less adequate accounts of how the world works, scientific methods provide more or less adequate ways of exploration, evaluation and discovery:

Frameworks of understanding serve as temporary resolutions as we participate in creating our worlds. We need them but need to 'hold them lightly' and be ready to discard them when they are in danger of becoming rigid and reified” (Reason and Marshall, 2001, p.417).

## **Section 1. Methodology**

In order to achieve a sufficiently flexible, robust and ‘fit for purpose’ approach I use more than one research method and more than one source of data. Freud (1973, p.210) describes psychoanalytic research methodology as being both inductive and scientific in that it formulates hypotheses based on detailed and accumulative observations, which are then tested in relation to their explanatory power:

We bring expectations with us into the work, but they must be forcibly held back. By observation, now at one point and now at another, we come

upon something new... We put forward conjectures, we construct hypotheses, which we withdraw if they are not confirmed....

In his discussion of the scientific method, Rustin (2002, pp.123-124) explores the longstanding division between the 'sciences', searching for causal relations, and the humanities, largely concerned with meanings. He perceives the 'human sciences' as being historically positioned "...uncomfortably in the middle of the division..." While some, for example psychology and economics, aim to be as scientific as possible, others, including cultural and social anthropology, rather than on offering causal explanations, are exploratory. Describing what he calls 'normal science' – in distinction to 'revolutionary science' - as "puzzle-solving", Kuhn (1996, p.35) states that "Perhaps the most striking feature of the normal research problems...is how little they aim to produce major novelties, conceptual or phenomenal." However, he argues that "...the results gained in normal research are significant because they add to the scope and precision with which the paradigm can be applied" (ibid, p. 36).

The approach of the cultural anthropologist, Clifford Geertz, has a specific resemblance to that of psychoanalysis in that it combines an inductive methodology with the recognition of a pre-existing conceptual framework. He proposes that the appropriate state of mind for commencing fieldwork unites a "...general bewilderment as to what the devil is going on" with:

...theoretical ideas... adopted from other, related studies, and, refined in the process, applied to new interpretive problems. If they cease being useful with respect to such problems, they tend to stop being used and are more or less abandoned (Geertz, 2000, p.27).

In a manner reminiscent of Glaser And Strauss, Geertz (2000, pp.5-6) prioritises methodology. "If you want to understand what a science is, you should look in the first instance not at its theories or its findings...(rather) at what the practitioners of it do." His argument for the validity of 'thick description' as a scientific method can be applied to psychoanalytic research. Hindle (2007, p.71), for example, sets out to obtain a small number of detailed, meaningful, 'thick' case studies for her psychoanalytically informed study of siblings in the care system. For Geertz, anthropological accounts are interpretations, or 'guesses at meanings', and the task of the researcher is to assess the guesses and to draw conclusions from the better ones, rather than discovering any

grand theoretical framework. This view, which accords with Kuhn's (1996) depiction of the task of 'normal science' as well as with Polanyi's (1958) concept of 'personal knowledge', resonates with how I envisage my research. Greenwood and Lowenthal (2005, p.192) adopt the term 'tacit knowledge' to describe the type of knowledge that is "...associated with the messiness of real practice situations, a knowledge that emerges as a consequence of experience rather than from a preoccupation with proof." In acknowledging the existence and value of 'working', 'tacit', or 'personal' knowledge', I also accept that such knowledge will inevitably be a partial and approximate version of reality, similar to Nagel's (1986) idea of a 'partial view from somewhere' (c.f. chapter 2).

### **1.1 'The objective use of subjectivity'**

"Each observation rests on the observer's subjective experience in the observed organisation as much as on their objective description of what they can observe" (Hinshelwood and Skogstad, 2000a, pp.15-16).

Polanyi (1974, p.214) puts forward his concept of 'personal knowledge' as a way of resolving the tension between objectivity and subjectivity. He argues for 'intellectual commitment', which involves a "...fusion of the personal and the objective." Through so doing, he aims to achieve "...a frame of mind in which I may hold firmly to what I believe to be true, even though I know that it might conceivably be false" (1974, *ibid*). McLaren (1991, p.154, italics in original) stresses the importance of the researcher having "an understanding of the lived discourses (and the contradictions, elisions, and fissures contained therein) of the subjects he or she is studying and this means *feeling* the everyday experiences of subjects." It is just these contradictions, elisions and fissures that Hollway (2008) addresses in putting forward a psychoanalytically informed, theoretical model of the 'defended self'. She argues that a universal need to construct and maintain unconscious defences against the full impact of painful emotional realities makes it more or less impossible for a person to give an objective or transparent account of their actions, thoughts and feelings. The researcher, therefore, needs to take this into account when trying to understand what the research subject is communicating. She further argues that the

concept of the 'defended self', based on the subjective experience of reality, is equally applicable to the researcher. She makes use of the psychoanalytic concepts of projection, introjection and projective identification in constructing her argument that researchers have the potential to use their subjectivity as 'an instrument of knowing'. Based on the recognition of projective identification as an unconscious defence mechanism through which unwanted aspects of oneself are lodged in another person, Hollway builds a research tool, derived from the concept of the counter-transference. She argues that this tool can provide the researcher with knowledge about the subject's 'defended self' and proposes that "it is possible to build safeguards into research to help awareness of these threats to objectivity" (Hollway, 2008, p.151). The critique of objectivity inherent in a psychoanalytic approach is also germane to systems theory. "The systemic perspective encourages the observer to see himself as 'part of the system' and to look for the effect that the act of observing and defining problems will have on what he is observing" (Campbell *et al.*, 1994, p.13).

The positivist position that scientific observations are the only basis for accessing and assessing scientific truths would logically entail that arguments not based on observable data should be discredited and discounted. Geertz, Polanyi and, critically for my research, psychoanalysis all subscribe to a version of the positivist claim that objects in the world have meaning prior to and independent of our consciousness of them. They also believe, however, that reality, for a number of reasons including the researcher's values and assumptions, is elusive. I subscribe to a view of objectivity that recognises and attempts to explicate these inevitable values and biases. To the extent that I argue for the methodological validity of attempting to discover meaning through a process of informed, explorative guesswork, my approach is hermeneutic. It sets out to explore, extend and enhance the range and depth of the potential meanings and interpretations that can be ascribed to events, situations and processes. Findings derived from this type of approach, rather than being assessed as objectively 'true' or 'false', are evaluated for their ability to provide convincing and generative hypotheses or explanations for the phenomena being studied. The psychoanalytic theory of mind to which I subscribe argues that each person has an unconscious part of the mind which, while on a day to day basis is largely inaccessible, massively influences our beliefs, ideas and

perceptions at every level from intra-psychic dynamics to those operative in large social, organisational and political formations. Although it is possible to develop an awareness of 'the unconscious at work' (Obholzer and Zagier Roberts, 1994b), as Main (1989, p.213) points out "The trained, disciplined use of subjectivity as a source of scientific information is rare".

## **1.2 Ways of seeing: participant observation and psychoanalytically informed observation**

Observation is central to my methodological approach. According to Glaser and Strauss (1967, p.251) "The root source of all significant theorizing is the sensitive insights of the observer himself". I make use of two distinct but overlapping forms of observation, which are participant observation and psychoanalytically informed observation.

### **Participant observation**

According to Hinshelwood and Skogstad (2000b, p.25) "The method of observing organisations is close to fieldwork in anthropology and sociology, whilst its psychoanalytic framework of concepts is shared with infant observation." In my fieldwork I take up an observational stance in relation to the processes and dynamics involved in undertaking and disseminating state of mind reports for 'looked after' adolescents. This involves observing my own responses and behaviour, those of the young people and those of professional colleagues. In addition it requires that I reflect on my practice and responses, including my value driven assumptions and counter-transference feelings (c.f. Schon's (1983) 'reflection in action' and 'reflection on action'). Kleinman (1991, p.185) argues that because "emotions express values" we need to allow for the possibility that cherished values may be under threat" (1991, *ibid*).

Social scientists undertaking fieldwork frequently adopt a participant observer role. This combines a level of participation in the lives and activities of those being studied with an observational stance that allows the researcher to maintain some professional distance and detachment. Inevitably this dual role will cause tension for the researcher that, if not recognised and sufficiently well

processed, may become toxic, thereby potentially derailing the research enterprise. This tension is exacerbated for a practitioner-researcher (c.f. section 4).

In early ethnographic studies this inherent tension is evaded and denied by the use of a psychological distancing technique that sets up the observed as the exotic 'other', a defence achieved at least partially through the choice of subject. The fieldwork on which classic monographs such as Malinowski's (1922) 'Argonauts of the Western Pacific' is based generally takes place in communities geographically and culturally far removed from the researcher's own life experiences. Social scientists have subsequently come to recognise that "...field-workers engage not just in the analysis of field sites but in their active production" (McLaren, 1991, p.150). To borrow a systemic term, one could say they engage in a type of co-construction.

In a related shift of focus researchers increasingly study the communities and organisations in which they themselves live and/or work. A contemporary example is provided by a recent social anthropology PhD research project analysing local child minding networks in East London on which the researcher, as a working parent with four young children, depended during her research (O'Connell, 2008). As ethnography has become more closely aligned with other 'practice-near' and reflective types of research, it now shares with them an awareness of the impact of the experiences and emotions of the researcher, as well as of those being researched, on every stage of the research process.

#### *Psychoanalytically informed observation*

"Observation of social processes may provide one means of studying, as through a magnifying glass, the operation of paranoid and depressive anxieties and the defences built up against them" (Jaques, 1955, p.498).

Psychoanalytic observation as a research technique informs contemporary psychosocial research in social anthropology and sociology. Reflecting on his anthropological fieldwork, Van Maanen (1991, p.40) writes that "Understanding...comes largely from being caught up in the same life situation and circumstances as those one studies. One knows how others feel because

one feels it too.” According to Wengraf and Chamberlayne:

In research terms, both practitioners and users often turn themselves to begin with into ‘observers’ of the practice-situations in which they...are active agents. Consideration of the lived experience and emotions of people who take the role of ‘observers’ (and interpretation-makers and writers-up) may well be edging towards a psychodynamic approach to research (2004, p.277).

Such awareness is central to psychoanalytic observational studies, which are predicated on the centrality of the unconscious or ‘internal worlds’ of both researcher and researched. Psychoanalytic observation, including its application to wider psychosocial research contexts, while similar in some respects to participant observation, is a distinct methodology. Bick’s (1964, 1986) interest in developing the technique of psychoanalytic infant observation is underpinned by a Kleinian understanding of the infant’s sometimes acutely painful, even temporarily unbearable, anxiety. From this insight, she evolved her theory of the function of the skin as holding the baby together emotionally as well as physically and the related idea of ‘second skin’ defences. She also highlights the anxiety of the main carer - usually the mother - in relation to understanding and meeting her baby’s needs. She argues that both infant and primary carer erect unconscious psychological defences when anxiety threatens to overwhelm them (Bick 1964, 1986; Rustin 1997).

Bick (2002, p.51) emphasises the potential of psychoanalytic observation as “training for scientific data collection and thought.” As does grounded theory, participant observation and other inductive approaches, her methodology stresses “the importance of consecutive observation...one may see an apparent pattern emerging in one observation, but one can only accept it as significant if it is repeated in the same, or similar, situation in many subsequent observations” (2002, pp.47-48). In her discussion of the observer’s role in psychoanalytic infant observation Bick refers to the observer in a generalised way as “a privileged and therefore grateful participant observer” (2002, p.39). Her methodology, however, emphasises the central importance of the observer recognising how and when he is projected into, which projections may in turn “intensify his own internal conflicts” (2002, *ibid*). What distinguishes psychoanalytic observation from participant observation and related approaches is this close and continuous attention to transference and counter-transference

dynamics and to projective identification as a form of communication. She highlights how the student/observer learns to become increasingly aware of the range of primitive anxieties experienced by both carer and infant and to manage these emotions within her/himself so that they become important sources of information.

In order for the clinician or psychoanalytically informed researcher to sustain this close attention, s/he needs to develop a capacity to enter a state of mind similar to that described by Bion (1962a, 1962b) as one of 'maternal reverie'. This will enable the receiving mind to accept and contain, rather than defend against, painful projections including distress, rage, despair and confusion. The observer is asked to try to put aside theoretical preconceptions that can encourage premature decisions about what is significant. Recognition of both the importance and also the near impossibility of carrying out this request, enables the observer - whether clinician or researcher - to avoid assuming the disingenuous stance of 'observer impartiality' (Rhode 2004). Bick (2002, p.51) acknowledges "how difficult it is to...collect facts free from interpretation." She recommends psychoanalytic infant observation as a means of learning "to watch and feel before jumping in with theories" (2002, *ibid*).

There are several examples from the 1950s and 1960s of psychoanalytic observation being applied to organisational contexts, including Menzies' (1960) study of a general hospital, Miller and Gwynne's (1972) study of residential care for the physically disabled and Bott's (1976) study of a psychiatric hospital. More recently Hollway (2008) has adapted the method of psychoanalytic infant observation, developed in clinical practice and clinical research contexts, to her psychosocial research study of the developing mother infant relationship in an East London neighbourhood.

### **1.3 'Muddling through': reflective research**

There are those who choose the swampy lowlands. They deliberately involve themselves in messy but crucially important problems and, when asked to describe their methods of enquiry, they speak of experience, trial and error, intuition, and muddling through (Schon, 1983, p.43).

As a clinician attempting to research my own as well as other people's practice, I find Schon's (1983, 1987) ideas of particular interest. These are: his concept of 'reflection-in-action' (1983, p. ix) which involves a capacity for critical reflection on one's own practice; interweaving practitioner and researcher roles during one's career; and an interest in situations and contexts that are complex, novel, uncertain and messy. Schon (1983, pp.309-319) identifies several types of reflective research. The one he calls 'frame analysis' has similarities with positioning theory: "Dialogue is a type of conversation based on particular principles that make it possible for people to appreciate and explore other positions and to introduce difference without producing defensiveness" (Campbell, 2009, pp.4-5). Of most relevance, however, to my research approach are his ideas about the "...methods of inquiry and the overarching theories of phenomena, from which practitioners may develop on-the-spot variations" (1983, p.309). He further differentiates between, on the one hand, what he calls an 'action science' - similar to Lewin's (1946) concept of 'action-research' - and, on the other hand, the use of an interpretative framework, for example that of psychoanalytic theory and practice, to 'restructure' what is going on (Schon, 1983, pp.318-319). It is the latter that resonates with my research intention.

#### **1.4 An ethnographic approach**

The term 'ethnographic approach' applies loosely to any qualitative research, the purpose of which is to provide 'thick description', that is a detailed, in depth description of everyday life and practice. Geertz (2000) aims to provide 'webs of meaning' which are cultural interpretations of the phenomena under study. He contends that the 'complex specificness' of the findings arrived at by "...long-term, mainly (though not exclusively) qualitative, highly participative and almost obsessively fine-combed field study in confined contexts..." (2000, p.23) contributes to an understanding of 'mega-concepts', among which he lists structure, integration and conflict, all of which have relevance to my own research. Geertz disarmingly acknowledges that what he calls "this backward order of things – first you write and then you figure out what you are writing

about...” (2000, p.v) is often standard procedure in his discipline of cultural anthropology. The following description - with the caveat that instead of ‘going off’ anywhere, I remained ‘at home’ in my own workplace - could apply to my methodology and has echoes of Schon’s (1983) notion of ‘muddling through’.

We go off to those places or, increasingly, these days, ones closer by, with some general notions of what we would like to look into and how we might go about looking into them. We then in fact look into them (or, often enough, look instead into others that turn out to be more interesting), and after doing so we return to sort through our notes and memories, both of them defective, to see what we might have uncovered that clarifies anything or leads onto useful revisions of received ideas, our own or someone else’s about something or other (2000, pp. v-vi).

In ethnography, as in qualitative research more generally, the centrality of the researcher’s subjectivity is increasingly recognised. Painful feelings of self-doubt, uncertainty, frustration, anger, disappointment and ambivalence, alongside more positive emotions such as curiosity, excitement and satisfaction, are understood to contribute significantly towards shaping the research experience. (In section 2 I discuss the frustration, verging on a sense of hopelessness and failure, that I felt at times when carrying out my research.) In addition, the choice of research subject, its theoretical underpinning and chosen methodology are identified as being influenced by the researcher’s personal and professional background, experiences, political perspective and motivation. Fetterman (1991, p.90) warns that the researcher does not begin fieldwork devoid of theory and/or personal values. “The ethnographer enters the field with an open mind, not an empty head...[s/he] begins with a problem, a theory or model, a research design, specific data collection techniques, tools for analysis and a specific writing style.” Bott’s (1976) study of a psychiatric hospital is a pioneering example of an ethnography underpinned by a psychoanalytic theoretical framework. From evidence accrued over several years of intermittent fieldwork, she argues that many of the conflicts played out between staff, patients and families are manifestations of intrinsic tensions facing the hospital staff because of the conflicting institutional aims of providing care, treatment and control. She understands these tensions as reflecting a much wider underlying defensive denial of societal responsibility for the care of the mentally ill. Her methodological approach resembles that of thematic analysis and grounded theory in that meaning gradually emerges through the systematic interrogation of the ethnographic data, rather than being superimposed on it.

Glaser and Strauss (1967, p.40) comment on the potential of fieldwork to discover generative categories:

In fieldwork...general relations are often discovered in vivo; that is, the field worker literally sees them occur. This aspect of the 'real life' character of fieldwork deserves emphasis, for it is an important dividend in generating theory.

A second similarity between the ethnographic approach and grounded theory is that both use a variant of the concept of saturation as a significant pragmatic criterion for recognising when the collection of research data can be more or less safely concluded:

Because our understanding of the social world is necessarily incomplete and imperfect, representing an approximation and oversimplification, no study can ever be considered finished... The question to ask is not "when is the study finished?" but "when does the fieldwork yield diminishing returns? (Taylor, 1991, p. 242)

Thirdly, both view knowledge acquisition and understanding as a cyclical process whereby provisional insights and hypotheses are recursively compared and tested against observational data in an iterative manner and revised as/when necessary. Throughout this process, the researcher attempts to develop an ability to move back and forward between the micro and macro levels of observation and analysis in order to obtain some breadth as well as depth of perspective and understanding. (I discuss grounded theory and thematic analysis in section 3.)

## **Section 2. Research design**

### **2.1 Data sources: reflective case studies and transcripts of focus groups**

My data comprises seen and unseen, direct and indirect, source material. The visible material includes my observations of interactions; while the unseen includes my counter-transference responses. Although I rely substantially on information obtained directly, i.e. reflective case studies and focus group transcripts; I also make use of indirect, background information about the young people in my study, collected while compiling my mental health assessments. This includes: family and developmental histories; written and verbal referral

information; case files and notes; professional reports; and information exchanged during meetings with key professionals in the young people's support networks, all of which information is anonymised. My two reflective case studies are a distillation of my contemporaneous fieldwork notes, a type of process analysis, of the various phases of my state of mind assessments, from initial referral to dissemination. In compiling these case studies I draw, inter alia, on my psychoanalytically informed observations; on the young people's verbal and non-verbal communications to me and other professionals; and on the impact of these on me (my counter-transference).

My second substantial source of direct data derives from the transcripts of two focus group interviews, carried out towards the end of my research with two different categories of workers, both part of the young people's professional support networks. The first focus group comprises six members, including the manager and deputy manager, of the residential care team working in Norfolk House. The second focus group comprises three CAMHS clinicians from different disciplines: psychoanalytic child psychotherapy, systemic family therapy and nursing, all based in IAT. My intention in carrying out these interviews is to provide more evidence for, and to test the wider relevance of, the themes and sub-themes derived from my case studies.

## **2.2 Fieldwork**

While studying social anthropology as a postgraduate student, I carried out fieldwork researching Hong Kong Chinese family patterns both in London and Hong Kong New Territories. Partially for this reason, when thinking about my research subject and planning the research process, I wanted to incorporate a fieldwork phase into my research design. Patton (1980) points out that fieldwork is not a single method or technique but instead an accumulation of observations, interviewing and document analysis.

### **Case studies**

"The messy tangle of relationships which cases typically present just *is* the ways things are" (Cooper and Webb, 1999, p.120).

The aim of my 'practice-near', applied psychoanalytic research study is to systematically analyse a small number of cases in which I have been involved as a clinician. This case study approach seeks to develop "...hypotheses or theories that are grounded in the data itself, derived from a constant interplay between observation and understanding" (Midgley, 2004, p.92). What is important in both clinical and applied research is the initial emphasis on obtaining an in depth understanding of the specific material within one case example, however 'case' is defined. Only then does the researcher move incrementally to add and combine material from one or more other cases, with the aim of eventually 'saturating' the explanatory categories, meaning that the addition of further examples will not significantly increase understanding of the categories or themes under study. The long established use of psychoanalytic case studies for research purposes has links with, and might even be conceptualised as a precursor to, the methodology known as qualitative thematic analysis, of which grounded theory is sometimes considered to be a sub-type (Midgley, 2004, 2006; Braun and Clarke 2006). Insights, themes, patterns and hypotheses are arrived at through the analyst's detailed observation, recording and reflections on what has taken place in the consulting room over a number of psychoanalytic sessions:

Since accurate evidence is not so crucial for generating theory, the kind of evidence, as well as the number of cases, is also not so crucial. A single case can indicate a general conceptual category or property; a few more cases can confirm the indication (Glaser and Strauss 1967, p.30).

The type of understanding gained from the psychoanalytic case study method, although provisional, shares with grounded theory and also with what Braun and Clarke (2006) describe as 'latent' and/or 'theoretical' forms of thematic analysis, the potential to generate integrated theory.

### Focus group interviews

I undertook two focus group interviews. The first interview was held with six members of the Norfolk House residential care team, the second interview, undertaken nine months later, was undertaken with three CAMHS clinicians. My aim was to supplement and complement the evidential base for my analysis provided by my two case studies. In carrying out the focus group interviews I used a semi-structured interview format to ensure areas I wanted to explore with participants were covered, while allowing potential flexibility in following up

participant responses. My intention, in asking mainly open-ended questions, was to afford opportunities to participants for reflection on their experiences of those processes and dynamics in professional networks that are the focus of my research. In describing focus groups as 'structured eavesdropping' Barbour (2007, p. 35) intends to stress their interactive aspect. Kitzinger (1995) also emphasises that the interaction, communication and overall dynamic between members are important aspects of focus group interviews. I attempt to acknowledge this important aspect of focus groups when I analyse the interviews in chapter 6.

Both focus groups were recruited from pre-existing groups of workers, most of whom I had previously known professionally. I met both groups in their work places, during working hours. The RCWs incorporated their focus group, which lasted approximately one hour, into one of their weekly team meetings. The manager and deputy manager of Norfolk House participated in the group. Their occasional differences of opinion and the tendency of the former often to 'have the last word' on a topic inevitably impacted on the overall group dynamic, but did not noticeably damp down a lively discussion. The two groups differed in several ways. The CAMHS group comprised one female and two males whereas the RCW group comprised four females and two males. While all the clinicians were in their mid years, the RCWs ranged between mid twenties and late middle age. Perhaps more significantly, the two groups differed with respect to their roles, tasks and positions within the professional networks. However, the two interviews reveal some striking similarities between points of view expressed across the groups; and also differences of opinion within them. (I discuss these in chapter 6.)

#### *Difficulties in collecting data and sampling considerations*

I originally intended to undertake six case studies of young people placed at Norfolk House, using as my sample the first six young people with whom I undertook state of mind assessments after receiving the necessary authorisations to proceed with my research. I actually completed assessments and wrote draft reflective case studies on two boys and four girls aged between twelve and fifteen. In planning my research I had decided I would not ask a young person if they were willing to be a research participant until after I had

completed his or her state of mind assessment. My reason was that I did not want to risk compromising an assessment because s/he might feel that my interest in them and/or my recommendations could be influenced by whether or not they agreed to be a research participant. Once a report was completed, I made every effort to seek the young person's informed consent. However, because of their status as LAC, their 'gatekeeper' was, appropriately, children's services. Over the following three years I repeatedly contacted the relevant social workers and also their line managers, by phone, email, letter and occasionally in person. I asked for their support and cooperation in arranging to meet with the young subjects of my state of mind reports in order to discuss with the latter my request for their participation in my research. No one ever refused outright to assist me. However, social workers changed teams or left the department; and managers tended not to respond. I experienced feelings of increasing anxiety, frustration, helplessness and failure. These were punctuated by occasional hopeful interludes as, for example, when the social worker of one of the young people informed me that she had spoken with her client who was willing in principle to give her consent but was just now preoccupied with exam revision. When I re-contacted the social worker some time later, she inferred that her client no longer had any interest in meeting me. My overall sense was of being confronted by an enormous, systemic ambivalence. I understood very well that the young people might want to turn their backs on an extremely painful period of their lives, for example during the time I had worked with this young girl she had attempted suicide and also disclosed historic sexual abuse in her country of origin. I also appreciated that her extremely caring and conscientious social worker might want to protect her from the possibility of re-enacted trauma. In the majority of the six cases, however, my requests elicited minimal or no response. Rather than receiving any clear rejections, it felt as though my requests never quite reached the top of anyone's 'must respond' list, whether that of field social worker or assistant director. In my more paranoid moments I wondered if this was entirely coincidental rather than being, as it almost certainly was, just another example of the individual and institutional defences that are the subject of my research study. I have also wondered if my dual role as both clinician and researcher generated some confusion and possibly apprehension among my colleagues in children's services, although it did not seem to deter those working in either CAMHS or the voluntary sector. (I

discuss the challenge of being a researcher/clinician in a later section.) The two young people who agreed to meet me to find out about my research and subsequently gave their consent were already seventeen and eighteen years old - having been twelve and fourteen respectively when I undertook their state of mind assessments - and therefore of an age to act in their own right. By that time, however, I had lost contact with another two of the other young people in my original sample and had learned through their professional networks that the final two did not want me to contact them.

I had a similar experience in relation to my proposed schedule of interviews with professionals. Barbour (2007, p.42) refers to factors informing the researcher's decision whether to conduct individual interviews or focus groups. Having initially intended to use both, I was only able to carry out the latter. In addition to the two focus groups on which I draw in my research, I had hoped to undertake a third interview with a group of Independent Reviewing Officers (IROs). In my experience the IRO is sometimes the social care professional with the most continuous, though slight and periodic, contact – in some cases amounting to several years - with a LAC. I also wanted to undertake individual, forty-five minute interviews, using a semi-structured interview schedule, with the current social workers of all six of the young people in my initial sample. However, unlike the management of CAMHS and of the voluntary agency running Norfolk House, I received no response from line management in children's services to my repeated requests to undertake the focus group and individual interviews.

A frequent criticism of the case study approach is the unsystematic, even haphazard way in which cases may be selected. As noted above, my initial approach to sampling, although unsuccessful, was not haphazard. I decided against using prescriptive criteria such as gender, age, extent and/or type of problem that has brought the young person into the care system. Instead I chose a 'whoever came through the door' approach, that is to include each young resident of Norfolk House for whom I was asked to undertake a mental health assessment until reaching my target of six assessments. The choice of sampling frame was largely pragmatic in that I had very little influence over the decision to request a mental health assessment. It seemed unlikely, moreover, that the introduction of more specific selection criteria than those already

provided by the context of my work would enhance exploration of the specific questions in which I was interested. As already noted, out of the six young people in the initial sample, I was able only to obtain consent from two.

My intention in using focus groups was to 'listen in' to a cross section of those working in professional support networks discussing issues pertinent to my research. My initial plan to gather information from three different groupings within the support networks working with LAC was stymied by my inability to undertake a focus group interview with IROs, which I had hoped would give a complementary perspective to that provided by the two other focus groups.

### **2.3 Practitioner/clinician research and first person action research**

...there has existed from the very first an inseparable bond between cure and research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results (Freud, 1955, p. 256).

Freud implies that psychoanalysis can be perceived as a type of practitioner research. Whether my psychosocial approach could be viewed as a modified variant of action research (AR) is much more debatable. Lewin (1946, p.35) envisages AR as a method of "...comparative research on the conditions and effects of various forms of social action and research leading to social action." In design it is "...a spiral of steps, each of which is composed of a circle of planning, action, and fact-finding about the result of the action" (1946, p.38). His approach, grafted onto a psychoanalytic theoretical framework, inspired a number of socio-technical research studies focussing on aspects of organisational change, including Miller and Gwynne (1972), carried out through the Tavistock Institute of Human Relations. The generic term 'action research' has subsequently been applied and adapted to a wide variety of methods aimed at both initiating action and also learning from the outcomes of that action. Within this 'extended family', Coghlan and Brannick (2005, p.xii) identify what they call 'first person action research', characterised by the developing capacity of the researcher to maintain an enquiring state of mind in relation to her own practice. I have asked myself whether my intention to observe and reflect on my

own practice, as well as on that of others, in my workplace equates with first person AR.

It is possible to compare and contrast my research approach with action research through listing a number of 'family resemblances' and differences. In a similar way to that of AR I adopt a developmental and iterative methodology. My research is undertaken in 'real time' and involves a significant fieldwork component. It is experiential and, like first person AR, grounded in my own work experience. My approach recognises the intrinsic value of the emergent learning process. It shares with AR the aim of producing practical knowledge that is potentially applicable to everyday working contexts; as well as a belief that 'objective' knowledge, in its positivist meaning, is impossible because the researcher is part of the world that s/he is studying. Finally, both are inductive methodologies, rooted in cycles of careful observation and reflection.

On the other hand, unlike AR, my approach does not set out, formally at least, to be a problem solving enterprise. It does not involve the participation and collaboration in problem identification and solving of those whose actions are being studied that is characteristic of action research. (It might, however, be argued that in first person AR the researcher is also the research subject). Nor does it complete a formal action research 'learning cycle' as advocated by Kolb (1988) in outlining the stages of his 'experiential learning cycle'. According to Coghlan and Brannick (2005, p.50):

The ethnographic role and the action researcher role are closely interconnected and sharply distinguished. The ethnographic observer attempts to be an unobtrusive observer of the inner life of an organisation, while the action researcher works at enabling obtrusive change.

I would argue that, overall, my research fits most comfortably under the wider umbrella of 'practitioner/clinician research' in which desired changes and learning outcomes, rather than being organisational, formal and collaborative as in AR, are orientated towards intra-psychic and interpersonal psychosocial processes.

## **Section 3. Data analysis: using thematic analysis and grounded theory**

In describing my approach to data analysis, I have borrowed Braun and Clarke's (2006, p.81) term 'grounded theory lite' in order to side-step the extensive debate about the precise boundaries between thematic analysis (TA) and grounded theory, which is arguably part of TA's wider methodological 'family'. TA, in turn, fits into the even broader family of qualitative research methodologies, most, if not all, of which are exploratory, focusing on process rather than outcomes. I agree with Braun and Clarke that TA offers an accessible and flexible research tool, offering theoretical flexibility in the search for patterns or themes as long as the researcher takes a clear and consistent approach and explicates her epistemological assumptions (c.f. section 1). This requires ongoing self-reflexivity (c.f. section 4). One important aspect of TA's flexibility is that it presents the researcher with a continuum, along which to locate her research approach. At one end of this continuum the research project is restricted to demarcating broad, descriptive patterns in the data. At the other end there is an ambition to identify underlying themes, from which it may be possible to construct interpretative hypotheses and engage in theory construction in a similar way to grounded theory:

...a thematic analysis at the latent level goes beyond the semantic content of the data, and starts to identify or examine the *underlying* ideas, assumptions, and conceptualizations – and ideologies – that are theorized as shaping or informing the semantic content of the data.... (Braun and Clarke, 2006, p.84, italics in original).

### **3.1 Grounded theory**

This is a systematic and largely inductive approach to research and data analysis, with the aim of generating theoretical concepts 'grounded' in the research material. Rather than offering an overarching conceptual framework, Glaser and Strauss (1967, p.3) provide a pragmatic, practice-near description of grounded theory as "a strategy for handling data in research, providing modes of conceptualization for describing and explaining." They conceptualise theory as "a process...an ever-developing entity, not as a perfected product" (1967,

p.32). Theory generation is therefore incremental, building on categories and their interrelations and taking account of both differences and similarities. In their view, hypothesis generation only requires sufficient evidence to “establish a suggestion – not an excessive piling up of evidence to establish a proof” (1967, p 40). Echoing Kuhn (1996), they argue that:

The great theorists have...given us models and guidelines for generating theory, so that with recent advances in data collection, conceptual systematization and analytic procedures, many of us can follow in their paths ... It does not take a “genius” to generate a useful grounded theory (Glaser and Strauss, 1967, p.11).

While acknowledging that the methodology of grounded theory generates ‘middle range’ theories, they consider that it also has the potential to generate formal or conceptual, as well as substantive, empirical or applied, theory (1967, pp.32-33). Along the continuum offered by a grounded theory approach I locate my research approach as being that of applied theory construction. I have in mind a set of interrelated questions, which are the focus of my research. I then start to collect, code and analyse the research data derived from my case studies and focus groups with the aim of organising it in a way that enables me to discover a number of themes and to generate working hypotheses about how these themes interrelate. I attempt during this process as far as possible to approach my material in a ‘theory free’ way. (I have previously discussed the limits of objectivity.)

#### *‘Patterns of meaning’: the search for themes*

In a grounded theory approach the researcher attempts to identify patterns in the source material. These are then re-applied to the original material and tested for their interpretative capacity. Through the incremental and iterative processes of comparison, categorisation, recategorisation, fracturing, interpretation and re-interpretation, insights become transformed into working hypotheses. Although these may ultimately develop into a credible and coherent substantive theoretical framework, my approach is less ambitious, which is why I am comfortable in accepting the term ‘grounded theory lite’ as a description of my own approach. While Glaser and Strauss refer to categories ‘emerging’ through close scrutiny of the data, Braun and Clarke (2006, p.80) criticise this term for its passivity, preferring the idea of ‘identifying’: “If themes ‘reside’ anywhere, they reside in our heads from our thinking about our data

and creating links as we understand them". In searching for patterns, I have tried to look out, not only for repetitive actions and sequences of interactions, but also for the recurring states of mind that might help to illuminate these. I started by reading over and over again all six of my original reflective case studies, as well as the anonymised specialist assessments informing them, in order to try to identify descriptive 'codes' or categories. An initial trawl through my data set arrived at the unwieldy and rather alarming number of thirty-four categories. I subsequently reviewed, redefined and renamed my initial categories several times, looking out for patterns both within and across the individual case studies - I had not yet carried out my focus group interviews. Although at a later stage of analysis I needed to focus exclusively on the case studies of the two young people who had given their informed consent to be research participants, I believe the inclusion of all six case studies at this initial stage of categorisation and pattern making indirectly contributed to and enriched my final data set. Gradually, through an iterative process, I was able to refine my original thirty-four categories into significantly fewer themes and sub-themes. At the same time, I was searching for identifiable relationships between these themes. According to Braun and Clarke (2006, p.82) "Researcher judgement is necessary to determine what a theme is...you need to retain some flexibility..." The availability of more than one case study as well as, later in my research, two focus groups has allowed me to generalise across cases and between types of data. It has also helped me to differentiate between findings that are transferable across my data set and those more restricted in scope.

#### *The constant comparative method and saturation*

As implied in the name, the constant comparative method involves a constant moving back and forward between one's data set, provisional categories identified and working hypotheses. This comparison is based on patterns identified between categories, a laborious and time-consuming process that is intrinsically recursive and developmental. In the constant comparative method, each emergent category and associated concept is tested for its capacity to contain and make sense of new material until the researcher considers it to have become 'saturated', i.e. to have no further capacity for organising the material under study. However, as Barbour (2007, pp.126-127) points out, any designated saturation point is likely to be both illusory and arbitrary. She,

therefore, advises the researcher to accept a 'good enough' saturation point, advice I found reassuring when trying to apply the notion of saturation to my own research.

Although largely an inductive methodology, grounded theory has a deductive aspect in that it makes use of the hypothetical-deductive method to test the categories and exploratory working hypotheses that have been inductively generated from the data (Shaffir and Stebbins, 1991, p.6). According to Patton (1980, p.47) "Discovery and verification mean moving back and forth between induction and deduction, between experience and reflection on experience, and between greater degrees of lesser degrees of naturalistic inquiry." When analysing my material, I tried gradually to build up a framework of understanding in relation to both observed interactions and also states of mind, the latter often experienced through my counter-transference feelings. I carried out my analysis, interweaving deductive with inductive methodologies, at different levels. Initially my analysis focused on individual reflective case studies or individual focus group transcripts. I followed this up by comparing and contrasting material between the two case studies and between the two focus groups. Finally I attempted to identify themes and search for patterns applicable across the whole data set, comprising case studies and focus groups.

### **3.2 Conducting the data analysis**

Grounded theory shares with psychoanalysis a belief that the social world is meaningful and, therefore, capable of being understood. While recognising that observations are 'theory laden' (Anderson, 2002, p. 337) I have approached my dataset – primarily two detailed reflective case studies – with what I hope is an open rather than an empty mind, within a psychoanalytic paradigm informed by concepts derived mainly from object relations theory. Subject to this caveat, grounded theory offers an inductive approach to theory generation, i.e. the theory is grounded in the qualitative data. It is a systematic and iterative methodology that uses increasingly refined processes of codification and classification in order to identify from within the dataset emergent 'core categories' – which in my research project I have called 'themes' - capable of

organising the material in ways which reveal patterned inter-relationships between categories.

Before starting to formally codify my data I had already made several indeterminate and disappointing attempts to organise material about the young people with whom I worked at Norfolk House. I had noted similarities and differences, including experiences with both their birth families and in care; and had constructed some very basic tables, scales and graphs which compared and contrasted them with respect, for example, to levels and frequency of anxiety, hopefulness, emotional volatility, acknowledgement or denial of dependency needs, self-harm or psychosomatic symptoms. It was not, however, until I adopted the much more systematic and rigorous processes of codification, fracturing and the constant comparative method of grounded theory that I began to make any effective progress in my analysis.

As an initial step, I created a provisional list of headings, or codes, from repeated close readings of the anonymised case studies relating to my initial sample of six young adolescents placed at Norfolk House, each one written soon after completing her or his state of mind assessment. All detailed the process from referral, through my sessions with the young person, to writing up and disseminating the assessment report and, finally, any follow-up work undertaken. I was careful to differentiate my reflective commentaries from the descriptive narratives by making two columns on the page and by using different typescripts. I searched the case studies several times, trying to identify codes, which I numbered sequentially. Through this process I gradually extrapolated from the data a list of forty-two provisional codes (from code 1, self-harm/suicidal ideation to code 42, 'safety in numbers'.) Realising part way through my research that I would be successful in obtaining informed consent from only two of the six young people in my initial sample, I restricted all further analysis to their two case studies. Although drawing exclusively on these two cases in my formal analysis, my initial trawl across all six cases has been of value to my subsequent, more restricted, dataset in assisting the signposting of potential codes and their interrelationships.

Having 'discovered' forty-two provisional codes emerging from my data, I continued to sift through the dataset, exploring different ways to sort the codes in order to learn if and how they might relate to each other, a process known as fracturing. My aim was to find ways of reorganising my initial codes into fewer and fewer groupings according to their apparent inter-relationships. I tried, for example, to cluster several codes under 'violence'; another grouping under 'perversity'; and a third under 'danger'. Under 'psychic retreat' I placed: absconding, elusiveness, evasiveness, isolation and avoidance, while under 'inertia' I tried placing together: drift, delays and disconnectedness. I explored, inter alia, whether there was a discernible association between psychologically absent and/or violent birth parents; perverse behaviour on the part of the young person; and instances of institutional abuse through omission or commission within the professional network. I also searched for overlaps between groupings, drawing spider diagrams that linked codes and clusters of codes. In these ways I began to identify from my codes more refined and inclusive categories.

In exploring the properties of these emerging categories, searching for both similarities and differences between them, I made use of the constant comparative method, a process through which findings are continually checked against the data. I hoped that this process of continual refinement would enable me to identify clusters of inter-related categories that might reveal core categories i.e. those capable of organising and making sense of the material. An example of the emergence of one such potential core category was the correlation, although not necessarily causal relationship, I thought I had identified, in both young people and workers, between the absence or collapse of a capacity to think and dysfunctional behaviour.

Of the forty-two codes I initially 'discovered', thirty-nine related seemed to relate primarily to the young people in my sample. Being curious about this apparent imbalance, I looked closely at the remaining three codes: 'pass the parcel' (code 7); 'holes in the net' – delays and gaps in the professional network (code 9); and 'being left to hold the baby' (code 32) that I had initially identified as relating primarily to those professionals in my dataset working with looked after adolescents. I wondered about the significance or otherwise, in terms of

organising principles, of the apparent diversity between these three codes. 'Pass the parcel' indicates a particular defensive response to an unbearable situation. 'Holes in the net', in contrast, refers to a failure by workers in the professional network to act in a joined-up manner and as such is an observation of a dysfunctional or pathological organisational environment. 'Being left to hold the baby' describes a painful emotional state. This prompted me to return to the full list of forty-two codes and re-sort them according to this three-way classification. By so doing I was able to identify twenty-eight codes potentially relating both to young people and to workers. Examples of dysfunctional or pathological environments included: 'making do' – scarcity of resources (code 8) and ineffective, uncontainable parental figures (code 11). Examples of painful feeling states included: 'missing out'- feelings of deprivation, marginalisation, and exclusion, leading to a sense of grievance' (code 25) and low self-esteem and feelings of hopelessness as well as, for workers, a sense of being deskilled (code 35). Examples, finally, from my revised 'both/and' cluster of defensive responses included: absconding (code 3); 'blame the victim' (code 13); and grandiosity and manic omnipotence (code 21).

Wanting/needing to strengthen my evidential base, I continued to fracture, sift and re-cluster my initial codes, checking repeatedly against my dataset. Through this process, I was eventually able to reduce the original forty-two into a significantly reduced number of more inclusive categories. By this time I was beginning to accrue evidence for at least the outlines of three interrelated clusters of core categories, capable of encompassing and connecting young people and their workers. In addition to certain shared environmental characteristics, these seemed to cluster around, on the one hand, feeling states (mainly painful) and, on the other hand, defensive reactions (often dysfunctional or even pathological) to those feelings. Through continued fracturing and the use of the constant comparative method I thought I was beginning to discern core categories with an organising capacity not only within but also across my two reflective case studies. I discovered, for example, that when professionals, feeling isolated and overwhelmed, find ways of 'looking away' or 'passing the parcel' young people's risk-taking and anti-social behaviour is likely to spiral. Having noted that the environment, feeling states and defensive responses of the young people in my dataset all seemed to find echoes in their professional

networks, I continued to search for more systematic evidence of professional mirroring and equivalences.

The constant comparative method enabled me to explore in increasing detail the properties of my emerging categories, which I kept attempting to refine until I began to feel reasonably confident that my case material was no longer providing useful evidence, i.e. that I was approaching what grounded theory refers to as saturation. By this time, I felt reasonably confident that I had discovered/identified in my dataset two groups of three core categories, or themes, each having a number of sub-themes. The first group of three relates to the external and internal worlds of the young people and their defensive responses; while the second, complementary group of three relate respectively to the external and internal worlds of workers in their professional support networks and to the defensive barriers they, in their turn, erect to defend against extremely painful feelings generated through contact with the young people.

*Addressing the process by which grounded theory type procedures came into connection with my use of counter-transference records*

Although the method of conducting the data analysis as I have described it may appear to be unilinear, it is in reality cyclical and iterative, looping back on itself over and over and for this reason resists a clear and concise delineation. Hollway and Jefferson (2013, p.153) describe it as, "...a continuing dialogue between the theoretical constructs that we use as resources for meaning-making and the data that we encounter." In this dialogue the data encountered is obtained not only from visible sources, for example observations of behavioural sequences, but also from unseen sources, including my counter-transference responses. These are informed by unconscious processes and states of mind and provide important emotional information or intelligence (Armstrong, 2005; Hollway and Jefferson 2013). My understanding of the counter-transference derives from Bion's (1959, 1970) development of the Kleinian (1946) concept of projective identification. Bion viewed 'normal' projective identification as a form of communication. In the clinical setting, the mechanism for receiving and making sense of this communication is through the analyst's counter-transference (Heinmann, 1950, 1960). According to

Kleinmann (2002, p. 380, italics in original) "...*what* researchers feel is much less important than *how we use those feelings* to understand the people we study. The complex feelings I experienced...eventually became resources for analysing the data." In making use of my counter-transference, I have tried to keep in mind the very real possibility that my own transference associations to what is being communicated may influence my counter-transference feelings, rendering them confusing, misleading or even self-deceptive. "Our feelings may be accurate or not; either way, they provide clues and hypotheses about ourselves and the world" (Kleinmann, 2002, p. 382). I noted previously that I kept my reflective commentary, including my counter-transference responses, separate from the descriptive narrative. This practice potentially enables, either myself at a later date or another reader, to make alternative or supplementary interpretations of the data to those I put forward here (Midgley, 2006). Walkerdine et al (2002, p. 182) ask how the researcher can know that she is not just projecting onto the research participants her own fantasies. They argue that, "...transferences, identifications and fantasies do not disappear when we are engaged in research...It is, therefore, crucial to acknowledge and attempt to understand what transferences and counter-transferences might be telling us as researchers"(ibid. pp.185-6). This involves, inter alia, attending to who the researcher may represent at any given moment for the research participant and vice versa.

In my counter-transference, I felt that Dermot at times transferred onto me his intense and turbulent feelings for his mother. During our first session he complained vociferously both about the staff at Norfolk House and also about the other young residents. I recalled that when his family had been evicted from their home, his mother had apparently prioritised her relationship with a man over taking care of Dermot and his siblings, generating in him a sense that he had been pushed out. I was a few minutes late for our meeting but he didn't express any sense of slight or overt anger towards me, seeming instead to transfer these feelings to other, less 'loaded' relationships. I wrote in my reflective commentary, "I wondered whether he was protecting his mother, and also me as a maternal transference object, from his deep anger and sense of grievance by channelling his resentment towards both the staff and the other young people in Norfolk House?" On another occasion, I reflected that, "I was

left feeling at the end of this particular session that he was communicating the intense distress, anger and confusion evoked by feeling alone because 'unclaimed' by parental adults. When he suddenly left the room I felt to some extent this was in order to protect me, as a maternal transference object, from the brunt of his rage." My counter-transference response towards Dermot was strongly maternal. I noted, for example, "Although he seemed to want to give me the impression he was able to look after himself, I felt anxiously and impotently protective towards him."

These powerful transference and counter-transference relationships extended to Dermot's relationship with his social worker and also the relationship between her and me. I mused about whether there was, "...an element of competition between myself and Dermot's social worker, at least from her perspective? Perhaps she felt cast in the role of bad mother to my good mother?" I also, however, could easily become the bad mother. This transition was most notable as our sessions were drawing to a close, leaving Dermot re-exposed to a withholding maternal object. Over this period he repeatedly evoked in me feelings of being diminished, redundant and 'dropped', which I understood as communications about the emotional pain of his early life experiences. Just as Dermot projected into me his distress, I felt that so too did his social worker. My commentary notes that, "On reading her comments about my work with Dermot in the transfer summary, while I recognised Dermot's ability/need to generate splits between professionals, I wondered whether to some extent this social worker also experienced an unconscious need to displace and project into me some of her own uncomfortable feelings of rejection and disappointment."

Like Dermot, Kerie was able to generate in workers, myself included, rapid oscillations between hope and hopelessness, sympathy and irritation, a sense of agency and inertia, which I understood as refractions of the way in which Kerie's internal world had been splintered as a result of her chaotic and abusive infantile experiences. She sometimes flooded me with turbulent feelings, which communicated her own intolerable feelings of marginalisation, loneliness, helplessness, confusion, anxiety and anger. Whether advertently or inadvertently, she often held back from any authentic contact with me. As well as being a defence, in depriving me of such contact she was involving me in the

sensation of her own privation and deprivation. In my notes I wrote of, “a feeling that she doesn’t get enough of what she really needs in order to sustain her because there is always someone ahead of her ‘in the queue’.”

In my dual role as researcher/clinician, not only did I, experience difficult and unwanted feelings, as did my colleagues but, like them, I also tried to erect a range of unconscious defensive barriers. Through paying close attention to my own transference feelings and to my counter-transference responses, I was able to incorporate into my dataset not just my feelings but also my defences and to deploy both as analytic tools. For example, my increasing awareness of a desire at times to withdraw into a ‘psychic retreat’ helped me to recognise Kerie’s own survival tactic of opting to ‘take cover’, which eventually emerged as a sub-theme of my third core category, ‘minds like minefields’.

### **3.3 Ethical issues raised by my research**

#### *Authorisation and ‘informed consent’*

My repeated requests to approach social workers and Independent Reviewing Officers, both as potential interviewees and also, in the former case, as ‘responsible adults’ in relation to their young clients, encountered a ‘wall of silence’ from management in children’s services. The titles of two sub-themes in my sixth and final theme, ‘when thinking becomes unbearable’, describe rather accurately what my counter-transference feelings led me to suspect might be taking place within the professional network. I call these sub-themes: ‘ways of looking away’ and ‘passing the parcel’. These two defensive responses, frequently adopted by workers, mirror a defence popular amongst LAC, that of ‘taking cover’. For whatever combination of reasons, management seemed to have ‘gone to ground’. For a considerable time, I was unsure how and even whether I would be able to progress my research. Having obtained, after a protracted application process lasting several months, formal authorisation from all the relevant authorities: two academic institutions; the Central Office for Research Ethics Committees (COREC); senior management in the children’s services of the London Borough in which I was working and in which I wanted to base my research and also of the voluntary sector organisation managing

Norfolk House on behalf of the local authority; and finally, my own line managers in CAMHS, I was completely taken aback by what I perceived to be the way my research design was derailed by the operation of informal and elusive organisational dynamics. With hindsight, this is ironic because these underlying dynamics constitute the focus of my research.

### Confidentiality and anonymity

I recognise the importance and complexity of questions relating to writing up, giving feedback, and disseminating my potentially sensitive research findings. I am also very aware of the overlap between confidentiality, anonymity, authorisation and informed consent. Menzies Lyth (1989b, p.41) comments from experience that:

One cannot, as a rule, disguise an institution effectively. One's clients are literate and interested in themselves and are entitled to be told where the work will be published. This means that results can be professionally and ethically published only when contents have been agreed and consent given for publication. Sometimes one cannot publish.

I am fairly certain that I would face significant difficulties in disseminating, let alone publishing, much of my research. Firstly and most importantly, no matter how carefully I tried to disguise or omit means of identification, I might not be able to ensure total confidentiality in relation to the identities of the two extremely vulnerable young people who have enabled me to pursue my research through giving their informed consent. The same applies to the identities of my former colleagues who took part in the two focus groups. Secondly, as a researcher/clinician, it would be massively challenging to effectively disguise my workplace and associated professional networks. Thirdly, my account of the research process could be perceived as critical of the role played by some senior colleagues.

### Who is the research for?

I initiated my research because I wanted to achieve something for myself. I was the one who identified it as being of interest and hopefully of value, not my professional colleagues and certainly not the young people who are at the heart of the study. In addition to addressing my own continuing professional development needs, I hope my research outcomes will contribute towards developing good practice. My study is, however, literally self-centred. Before

starting my research, I had anticipated some interest and also apprehension from professional colleagues about my chosen topic and would have welcomed and found helpful any opportunities to discuss my research with a range of colleagues. When the chance has occasionally presented itself, I have tried to find appropriate and accessible language to frame my ideas rather than relying on psychoanalytic terminology. However, with the exception of my CAMHS team, my research has elicited very little interest. I wonder whether some of my research findings are difficult to 'hear', in the same way as the material in my specialist mental health reports about the extremely painful external and internal worlds of young people in the care system may be emotionally difficult to take in and to take up (c.f. the title of my dissertation). While I was disappointed and slightly 'put out' by my colleagues' lack of interest in my research, it has been the delays and silences on the part of management, referred to in the previous sub-section, that have evoked in me painful feelings of confusion, frustration and anxious helplessness:

When we have strongly negative feelings in the field, we should ask ourselves: which of my values (or which valued self) is being threatened? In analyzing our reactions we should recognize what we want the organization or group to fulfill for us, why study this setting at this time? (Kleinman, 1991, p.185).

Certainly, my 'valued' self', i.e. my self perception as someone with agency, intending to carry out what I believed to be a worthwhile project, was undermined and threatened by the research obstacles in my way:

...the usual response to the re-stimulated anxiety is defensive, so that we project our anxiety out onto the research situation, thus distorting our perspectives in a way similar to the effect of counter-transference in psychotherapy... All inquirers need to explore how their unaware distress and psychological defences distort their inquiry (Reason and Marshall, 2001, p.414).

I am aware how such distortions, triggered by anxiety, can lead both research and researcher to become partisan and judgemental. This is an issue I have struggled with, trying to avoid the attribution of personalised responsibility and the individual allocation of blame for any difficulties encountered in my research.

## **Section 4. Evaluating a small scale, qualitative research study**

There are several difficulties in evaluating a rather eclectic qualitative research methodology such as mine that incorporates fieldwork, a case study approach and focus groups interviews. These include obtaining an accurate impression of the material being studied and replicating material (Shaffir and Stebbins, 1991). Because, however, qualitative research tends to explore different questions to quantitative studies, it is not necessary to use the same evaluation criteria. While recognising that “the methodological problem which the microscopic nature of ethnography presents is both real and critical”, Geertz (2000, p.23) believes that it can “be resolved - or, anyway, kept decently at bay - by realising that social actions are comments on more than themselves” (ibid).

A related difficulty is that of generalising from research findings based on case study, ethnographic and other qualitative approaches. The single case study has been criticised for presenting incomplete and selective information, woven into a coherent but highly subjective narrative (Midgley, 2004). On the other hand, when analysed through a variant of grounded theory, it may generate themes, concepts and working hypotheses. By using more than one case, as in my research project, it becomes possible to some extent to generalise, thereby extending the depth and breadth of analysis (Rhode, 2004). As early as the nineteen fifties, Main (1989, p.17) made use of a similar research approach to very good effect “Finer observations were sometimes made about the later cases, and, when this was so, the earlier cases were re-scrutinized for the presence or absence of corresponding phenomena.”

The question remains as to what are appropriate evaluation criteria for qualitative research, especially when carried out by a sole researcher/clinician wanting to reflect on relationships and dynamics in her own workplace? Schon (1983, p.42), contrasting rigour with relevance, confronts the practitioner/researcher with the question of whether to:

...stay on the high, hard ground where he can practice rigorously as he understands rigor, but where he is constrained to deal with problems of relatively little social importance? Or shall he descend to the swamp where he can engage the most important and challenging problems if he is willing to forsake technical rigor?

The issue of boundary delineation between the two aspects of the dual role presents a challenge to the researcher/clinician and may generate confusion, tension and suspicion in research participants and more widely in the practice/research environment. It also contains, like several other issues in evaluation, an ethical dimension, involving consent, confidentiality and anonymity. Navigational aides through Schon's sometimes treacherous 'swamp' include: the adoption of an appropriate and systematic interpretative framework; the use of reflection and reflexivity; and close attention to ensuring validity and reliability.

#### **4.1 Adopting an appropriate interpretative framework**

"Grounded theory, although highly systematic in its approach, also recognizes the generative value of insight 'whether borrowed or original' " (Glaser and Strauss, 1967, p.254). The transparent, highly detailed, systematic and incremental methodology of a grounded theory approach lends itself well to my small-scale study by providing a credible and coherent research methodology. In addition, the cyclical interrogation of data helps to address the criticism that in research relying mainly on case studies the evidential base is selectively chosen in order to support the research argument. It also enables some of the more positive attributes of the case study approach to come into their own. These include the potential for conceptual refinement and an ability to address complexity. A final significant advantage of this approach is that the distinction made between formal and substantive theory goes some way to addressing my difficulty in knowing how to approach my research in a state of mind sufficiently free of preconceived theory and personal, professional and cultural values. Glaser and Strauss argue that, while the researcher will inevitably approach the research material from a particular formal theoretical perspective, in my case the psychoanalytic paradigm, s/he can do so without detailed, substantive hypotheses, which will emerge - or be identified - gradually through the analysis.

## **4.2 Reflexivity**

As well as 'borrowed' theoretical insights, the researcher will inevitably bring to the research project her own personal, professional and cultural beliefs and values. It is essential, therefore, to attempt continuously to combine reflection with the capacity for self-reflexivity. I discuss the related notions of reflective practice and research in section 1. Reflexivity is a complementary, more dynamic concept, combining a capacity to reflect with an awareness of, and motivation to, explore the interconnectivity of researcher and object of research. Reflexivity acknowledges the various ways in which the researcher actively contributes to her data set (McLaren, 1991; Barbour, 2007). It also emphasises the importance of continually examining the impact of one's own assumptions and ideas both on the research topic and throughout the research process (Cooper and Webb, 1999; Burck, 2005). I use counter-transference as a research tool in this study and I would argue that my counter-transference feelings are reflexive in that they involve my responses to, as well as my reflections on, verbal and non verbal communications I receive from young people and colleagues. In a similar way, Barbour (2007, p.143) urges researchers to "Use reflexively your own reaction to excerpts from focus group discussions." My dual role as a researcher/clinician in and of itself requires me to exercise reflexivity in order to negotiate with any degree of competence, for myself and with others, the process of continuously switching back and forward between the different roles and their associated tasks.

Hollway (2008, p.151) identifies three 'safeguards' to "help awareness of...threats to objectivity" and also to provide her with the means to exercise reflexivity. These are a research seminar, a consultant and group analysis. Although these resources have not been available to me as a sole researcher/clinician, ongoing supervision of my research study contains an important reflexive component. Also, while my research topic has elicited very little interest in the wider professional network, close work colleagues, in particular those in IAT, have been willing to engage with me in sometimes difficult, always valuable, discussions about, inter alia, my choice of research questions; my overall approach; and my provisional findings. This process has some similarity with a technique in AR known as 'member validation', through

which preliminary results are shared and checked out with the participants (Midgley, 2004, p.104). Although not available to me in 'pure' form, both these informal discussions and more formal channels, such as team peer group supervisions, have enabled me to share and debate some of my thoughts, feelings and ideas in relation to my research study. Unfortunately, I have only infrequently had opportunities for similar discussions with colleagues in the wider support networks, for example, once when travelling to Wales by train with a social worker to visit a young person (not one of my sample) in their residential placement.

### **4.3 Validity and reliability**

Evaluating the validity of a research approach involves an assessment of its ability to make sense of the material under consideration, in my case the dynamics operating in professional support networks. Checking for validity may include scrutinising for incorrectness or bias the data; the argument; and/or the research findings. My original intention in incorporating focus group interviews into my research design towards the end of the fieldwork phase was to provide a type of triangulation, based on using more than one source of data, in order to test the validity and generalisability of the themes previously developed through applying a grounded theory approach to my case studies. However, Barbour (2007, p.46) points out the difficulty of accounting for discrepancies across different data sets. She proposes that "Rather than becoming caught up in irresolvable debate as to which dataset is most 'authentic', it is helpful to view focus groups and...any other forms of qualitative or quantitative data collection – as producing parallel datasets."

It is not possible to test the reliability of a small scale, qualitative research project undertaken in a naturalistic setting, using as a criterion the extent to which a measurement made repeatedly in identical circumstances will yield concordant results. However, a type of reliability can be achieved through the degree of consistency in relation to the research material that is provided by a grounded theory approach.

## **Summary**

While not subscribing to the positivist belief that an objective reality is discoverable, I argue that an ethnographic approach, encompassing both participant and psychoanalytically informed observation, can facilitate an understanding of psychosocial phenomena. As a researcher/clinician, I incorporate the use of reflective case studies and focus group interviews into my research design. I then utilise a grounded theory approach in order to analyse my data set.

## **Chapter 4. Thinking about troubled, troubling and sometimes troublesome young adolescents in the care system**

### **Introduction**

In this chapter I introduce the first three of my six overall themes, arrived at through applying a type of thematic analysis (Braun and Clarke, 2006) closely resembling grounded theory (Glaser and Strauss, 1967) to my case studies of two young 'looked after' adolescents, whom I have called Kerie and Dermot. These three themes, each of which has several sub-themes, describe respectively: the external worlds of young people like Kerie and Dermot; their internal worlds; and the defences which they erect to ward off their intense and chronic emotional pain and which result in their having 'minds like minefields'. I aim to demonstrate, through presenting material from my two case studies, the evidential base supporting my argument for the frequent recurrence of these themes and their sub-themes.

### **0.1 Summary of my two research cases, Kerie and Dermot**

#### **Kerie's history**

She is the oldest of several siblings. Her parents separated before her birth partly because of violence from her father towards her adolescent mother. The latter, who was estranged from her own birth family and experienced post-natal depression, had a second baby, born prematurely, when Kerie was only eighteen months old. As a very young child, Kerie was subjected to a chaotic home environment, multiple accommodation moves, neglect and abuse. Her mother entered relationships with several violent men, as a result of which Kerie not only witnessed domestic violence but was also physically and sexually abused by one or more of these men. Although she reported this abuse to her mother, the latter apparently did not believe her and was unable to protect Kerie against further abuse. Although children's services and subsequently, from time to time, CAMHS were involved with the family from her early childhood, Kerie was not taken into care until the age of eight. Before she was placed at Norfolk

House, she had experienced five foster care placements (from 3 days to 20 months duration) and two residential placements (of 7 months and 20 months duration). At her previous children's home, her disturbed behaviour and emotional distress had continued to escalate. She self-harmed, talked of wanting to kill herself, stole, lied, and threatened repeatedly to abscond. She also bullied and was bullied both in the home and at school, which she rarely attended. (All these patterns were repeated two years later during her placement at Norfolk House) The children's home, with the support of IAT, referred her to the local CAMHS. After an initial assessment the latter concluded that they could offer Kerie no additional support and containment to that already offered by her residential placement.

Kerie was twelve years old and on the point of being transferred to Norfolk House because her current residential placement had irrevocably broken down when the referral to IAT was reactivated, having been dormant during the eighteen months following the impasse within the professional network noted above. The management and staff team at Norfolk House shared with Kerie's LAC social worker serious reservations about the appropriateness of the placement both because she was younger than their designated age-range (13-16) and also because of her significant behavioural and emotional difficulties. There was, however, considerable pressure to accept her as her no other placement could be identified at short notice. Also, it was argued by children's services that she should come back to London in order to be closer to her birth family. Because of my liaison and consultancy role with Norfolk House I was requested by the residential home manager and the LAC social worker to undertake a state of mind/mental health assessment of Kerie. Over the two following months I succeeded in meeting with her twice formally out of four planned sessions, plus two unsuccessful attempts to hold a review meeting with her once I had written my draft report - She told me that she would find it 'boring' to hear what I had written. I also attended her LAC review and made several informal observations of her at Norfolk House.

After I had completed and circulated my report to key professionals, Kerie remained at Norfolk House for a further eight months before being transferred to a smaller residential home. When this placement broke down within two

months, she was moved to another residential home, this time outside London. However, this placement also broke down. Finally, an integrated residential, educational and therapeutic placement was identified, where Kerie remained until after her eighteenth birthday and where she was able to make all round, though limited, developmental progress. (aprox. 600 words)

### *My clinical assessment*

Kerie struggled to cope with the painful, angry feelings engendered by inadequate parenting from an emotionally unavailable mother. As a young child, she became extremely competitive with and envious of her younger siblings as well as assuming a parentified role towards them, which ambivalence continued to colour her relationships towards her own and substitute siblings, i.e. her peers. She also internalised a negative view of herself as a failure and a troublemaker, alongside a sense that reality, or at least her grasp of it, was elusive and slippery – she thought she had been abused but her mother said she hadn't. Who was she to believe? If she couldn't trust the perceptions and responses of the mother on whom she totally relied, then she was truly in trouble.

Kerie's strong, though insecure disorganised, attachment to her mother shaped her subsequent expectations of relationships with adults; while the unconscious defences she erected during early childhood to protect herself from being emotionally overwhelmed became increasingly dysfunctional in relation to her emotional, cognitive and social progress.

At times she used dissociation as a defensive response to unbearable early experiences. She was extremely needy and demanding of attention, which she sought by any means to hand, many of which were ultimately self-defeating as they reinforced her low self-esteem and alienated others. Her intense need for attention and acceptance, combined with her history of sexual abuse, inclined her to confuse sexually predatory behaviour with intimacy.

Deprived of emotional containment as a very young child, Kerie was unable to develop her own psychological, protective 'skin'. As a consequence, she was could not tolerate and process the painful emotions which, in consequence,

often overwhelmed her. This, in turn, undermined her capacity to build on good experiences and to access and make use of formal learning. It is probable that several of her physical conditions, including enuresis, nosebleeds and psoriasis were psychosomatic. Her tendency to steal, as well as being an expression of her great neediness, possibly related to a historical absence of appropriate boundaries. Her extreme emotional volatility, restlessness and 'wired up' quality may also have related to her lack of a strongly bounded sense of self, in the absence of which she needed continually to be physically 'on the go'. Her 'internal' world remained a very unpredictable and dangerous place, as had been her early 'external world'. She was, in consequence, fearful of exposing herself to the 'growing pains' of the psychosocial maturation process so that her emotional age lagged significantly behind her chronological age. Her unwillingness/ inability to settle also adversely impacted on her capacity to concentrate on academic work - she was assessed as having a very low reading age and mild learning difficulties. When boundaries were put in place, Kerie perceived them as punitive rather than protective and reacted against them through an escalation of risk-taking, anti-social and largely oral forms of self-harm, including scratching, biting and cutting.

In spite of grave obstacles to emotional development, Kerie was to some extent in touch with her dependency needs and wish to be adequately parented. She repeatedly tested the capacity of parental adults to provide an emotional environment sufficiently caring, robust and reliable to survive her very understandable accumulated pain, confusion, anger and distrust.

### *Dermot's history*

He is the youngest of three siblings. His parents came to the U.K. as adults and he was born and brought up in London. Both his parents misused substances, as a result of which Dermot was exposed to domestic violence as well as inconsistent and chaotic parenting. As a young child he also experienced neglect and at times emotional and physical abuse. At the age of six Dermot was briefly placed on the child protection register under the category of emotional abuse. There is no record of CAMHS involvement with his family prior to the Dermot's referral to IAT, aged fourteen. After being evicted from their home when Dermot was twelve, his parents separated and the family scattered.

He spent the following eighteen months 'living rough' and occasionally 'surfacing', for example when he spent time in a voluntary sector children's refuge. During this period his school attendance, previously patchy, petered out completely. While there, he was verbally and physically bullied by older boys. There is some evidence that he was 'self-medicating' with alcohol and drugs. He also attempted three paracetamol overdoses, the first one of which, according to Dermot, was triggered by a man attempting to sexually abuse him.

He was received into care at the age of fourteen after the police took out an emergency police protection order (PPO), having been called by Dermot to intervene in a physical fight with his mother. Both had been drinking. She accused Dermot of attempting to steal from her. A referral for a state of mind/mental health assessment was made to IAT by children's services soon after Dermot had been placed at Norfolk House. The referral was prompted by his communication to the duty social worker that he wanted help to address his emotional needs. Unusually among the young people with whom I worked, Dermot attended the IAT referral meeting with his social worker and myself. Over the next six weeks I met with him on a weekly basis (six sessions). After two review appointments, which he failed to attend, he and I met to review my draft assessment report, after which I circulated my finalised report to key professionals in his support network.

Dermot remained at Norfolk House for over eighteen months, during which time rehabilitation home and foster care were both unsuccessfully pursued. Finally, some months after his sixteenth birthday - the formal age limit for young people at the home - Dermot was placed in 'semi-independent accommodation' – a young person's hostel. Approximately one year later, by which time he was in regular work, he withdrew himself from the care of the local authority and made his own living arrangements.

### *My clinical assessment*

While Dermot presented as an articulate, self-confident young person and engaged easily with adults on a superficial level, he was also easily offended and extremely volatile. Alongside qualities of kindness and concern, he also had a very low tolerance level; tended to ignore attempts to provide constructive

limit setting; and could be jealous, possessive and attention seeking. When he felt under attack from the adult world – often perceived by him as rejecting, hostile, patronising and/or infantilising - he could become abruptly angry, resorting to verbal, even at times physical, abuse. Alternatively, he would seek to defend himself through omnipotent recourse to controlling and/or manipulative behaviour. There was also a defensively withdrawn and secretive side to his colourful personality which, despite the impressive range of practical self-care and coping skills he displayed, was a protective device to disguise deep hurt, confusion and vulnerability; as well as being an unconscious appeal to adults to demonstrate they cared enough to notice, become anxious and seek to re-connect with him. When, for example, he used to disappear for days on end from Norfolk House, I understood this as partially a test of whether the staff would be sufficiently concerned to attempt to find him – a dangerous adolescent form of emotional ‘hide and seek’. His insecure ambivalent attachment pattern resulted from the cumulative trauma of chronic neglect, exposure to domestic violence, intermittent emotional and physical abuse and at least one incident of sexual abuse. Dermot’s superficially flamboyant but difficult to read presentation of his sexual identity might be understood, at least in part, as an unconscious expression of his more general underlying insecurity and uncertainty. Also, his explicit and repeated demands for material goods could perhaps be understood as a concrete expression of an overwhelming sense of deprivation.

Dermot assumed the identity of a young carer, mainly in relation to his substance-misusing parents. While this role offered him a sense of agency and control, it also entailed a less positive element of intergenerational role confusion, if not outright role reversal. His stance of self-sufficiency and precocious maturity defensively masked his unmet dependency needs, which, nevertheless, inevitably erupted from time to time, taking the form of regressive, attention seeking/demanding behaviour and/or explosive outbursts of rage. While in reasonable physical health, Dermot experienced several psychosomatic symptoms, including serious sleep difficulties and headaches. He also suffered from panic attacks when in large groups. His addictive, self-destructive habits such as heavy smoking and substance misuse were both forms of self-harm and also expressions of his perceived need to evade and cut

himself off from painful experiences. Such habits also beg the question of how this vulnerable young boy was able to fund his habits, indicating that he might be exposed to sexual grooming/exploitation. Overall, Dermot demonstrated uneven and inconsistent psychological development, a mixture of precocious maturity and extreme neediness.

*My experience of the processes discussed in detail in the thesis*

My thesis explores the inter-relationships between, on the one hand, the extremely challenging home environments (external worlds), the intensely painful and difficult feelings they evoke in looked after adolescents (internal worlds) and the defensive barriers erected by the latter to ward off these feelings; and, on the other hand, the external and internal worlds and defensive responses of workers in the young people's professional networks. As a member of both Kerie's and Dermot's support networks, I inevitably shared in the experience of these processes.

I was very much part of a predominantly risk-avoidant organisational culture struggling to high quality social care and mental health services in the face of an economic climate characterised by radical cuts. In such a challenging and anxiety provoking environment, and despite policy injunctions to work in 'joined-up' ways, across both disciplines and agencies, I and my colleagues found it difficult to sufficiently loosen our hold on former 'tried and true' organisational allegiances in order to be able to experiment with novel professional identities and forms of collaborative working. In my work with both Kerie and Dermot, I frequently found myself, just like my colleagues, seeking refuge in our own professional comfort zones, with the result that our perceptions and recommendations fractured accordingly. This process was, perhaps, particularly noticeable in relation to the recommendations that accompanied my assessment reports, which were very never fully taken up for a variety of reasons apart from some almost certainly being misplaced. Others, explicitly or implicitly, included: lack of resources; a bias towards maintaining the status quo; and competing policy and professional priorities.

My internal world, most noticeably the unwelcome and difficult feelings often evoked through my direct and indirect work with Kerie and Dermot, is a primary

source of emotional intelligence on which my research draws. Kerie was at times able to fill me with painful and turbulent feelings which I tended to understand as a communication from her about her own confusion, distress and anger. She could generate in me, as in other members of the professional network, a sense of hope followed almost immediately by feelings of disappointment, inadequacy and hopelessness, as for example, when she showed me with apparent pride her bright, comfortable, bedroom. However, my hopeful anticipation that, in taking care of her room, Kerie was demonstrating some feelings of self-worth was quickly crushed when I was informed that she had 'trashed' her room the previous day and that it was staff who had imposed on it a sense of cheerful order. Kerie had a capacity to influence different workers, including me, to take up conflicting, sometimes rivalrous positions of hope or hopelessness in relation to her at any one time, rendered consistent and coherent thinking about her extremely difficult and reinforced the fragmented organisational environment previously referred to. Dermot was also able to generate in me strong feelings, for example an anxious, impotent desire to protect him. Like Kerie, he too could induce in me rapid alterations between, hope and near despair, sympathy and irritation, as for example, when he summarily 'dropped me' after having seemed to be engaged in our work.

It was not only my direct work with Kerie and Dermot that elicited strong feelings in me but also my interactions with colleagues. For example, even before Kerie was placed at Norfolk House, the residential staff team transmitted their sense of anxiety and urgency into me, in consequence of which I prioritised her referral. Later, the residential care workers imbued me with a sense of protective complicity in their feeling of having been unfairly left 'to hold a difficult baby'. The pressure I felt under to identify with their position led me to want to 'rescue' them through my report recommendations. I also shared with other workers in Kerie's support network, in particular her social worker, a generic sense of being flooded by unwanted responsibility and uncertainty. This anxiety crystallised for me on being asked to undertake an urgent assessment at a time when Kerie was making repeated threats to kill herself. Another feeling I shared at times with colleagues, and which relates both to a fractured environment and also to client/patient projections, was that of being unheard, either by management (parental figures) or by colleagues (siblings). Feelings of

marginalisation can induce a rather desperate desire to be invited/accepted into the network, as a prototype protective huddle. In her case study I noted in my commentary that, “I felt relieved and pleased when I received an invitation by email from the ART link social worker to visit Kerie’s new placement with her and the fieldwork social worker, as this seemed an opportunity for greater integration within the professional network.” However, this sense of security proved illusory. “Over the next couple of months I felt that I had lost touch with developments concerning Kerie’s future placement plans. I had no sense of the outcome of the previous heated communications between different parts of the professional network...I remain puzzled about the reason for this pronounced rupture of any contact, direct or indirect, with Kerie, which could only be negotiated through her social worker and other key members of the professional network, at a critical transitional time for her.”

I experienced a somewhat similar dynamic with Dermot’s social worker, whose elusive and distant relationship with me seemed to mirror his rootlessness and elusiveness. Noting that, “I was coming to feel more and more 'cancelled out' of the professional network by [this worker]” I wondered if there was, “...an element of competition between myself and Dermot’s social worker, at least from her perspective – perhaps she felt cast in the role of bad mother to my good mother?” On learning that this social worker had left the department not long after this, I wrote, “ I wondered if the social worker had to some extent run away from painful feelings of failure. With hindsight I ought to have tried harder and with more empathy to link up with her but my unprocessed negative feelings, including irritation amounting to anger, sense of injury and hurt and perhaps rivalry, blinded/prevented me! Once again, Dermot had managed an ephemeral but ultimately self-defeating ‘victory’.”

As with my shared experience of both the external and internal worlds of those taking part in the young people’s professional networks, I, like my colleagues, constructed defensive barriers with the more or less unconscious aim of protecting myself from exposure to the intensely painful feelings ricocheting between the looked after adolescents and their workers. I became aware after some reflection, for example, of a desire to withdraw into my own defensive ‘psychic retreat’ in order to avoid the full blast of Kerie’s almost intolerable

distress. Also, when contacted by her intensely anxious social worker, I detected in myself an irritated and irritable wish to 'lie low'/ 'look the other way' and hope someone else would take responsibility. On one occasion, I persuaded myself not to take the initiative in trying to galvanise the professional network because both my role and my time were limited. I noted in my reflective commentary. "With hindsight, I wonder if I was defensively 'passing the parcel' in a similar manner to that I had observed among other professionals." On the other hand, just as Kerie was apt to do, professionals, myself included, can be tempted to entertain unrealistic, even omnipotent, solutions. Wanting to support colleagues who felt deskilled and acutely anxious, and perhaps in order to demonstrate/win my 'full membership' rights to the professional network, on one occasion I engaged in a burst of manic activity, arranging additional interviews, meetings and specialist assessments even while doubting the value of so doing. I also felt under considerable pressure to provide, or at least to access on Kerie's behalf, a particular type of therapeutic support, i.e. individual psychoanalytic psychotherapy, which, in my assessment, she would not be able to effectively use. Again, despite trying to avoid foreclosing on the capacity to keep thinking in an exploratory manner, I sometimes found it almost impossible not to take up a particular position and in so doing become identified with one member or component of the professional network, in opposition to another/others, for example, Kerie's social worker 'against' education or the residential care team 'against' ART.

As with Kerie, in working with and on behalf of Dermot I often found myself responding defensively. My failure to establish a satisfactory working alliance with Dermot's social worker and in consequence frequently outside the 'information loop' left me feeling stuck with a sense of frustration and helpless irritation, as when I learned indirectly that Dermot's next LAC review, to which I had not been invited despite my written request, had very recently taken place, though not on the date provisionally agreed at the previous LAC review. In my reflective commentary I wrote, "I wondered just what I was being asked to carry on behalf of a rather dysfunctional and paralysed professional network. I, rather fancifully, had a sense of being scapegoated and cast out into the wilderness." Although I continued to feel very concerned about Dermot's uncertain situation in relation to both his placement and his education, once I had completed and

presented my assessment report my role as an IAT clinician was at an end unless requested by children's services to remain involved in Dermot's professional support network. This request did not materialise.

## **0.2 Adolescence as 'work in progress': developmental stage and state of mind**

Before moving on to the substantive part of this chapter, I contextualise my discussion of troubled adolescents by outlining some of the ordinary developmental challenges faced by children as they grow into early adolescence; as well as the expectations they have a right to assume will be met by their parental adults in order to enable them to reach psychological maturity. According to Parsons and Horne (2009, p.47) "The young person is in the course of development, a work in progress - and often still struggling with the psychological tasks of fairly early life." In the Kleinian developmental model, "the child's early object relations...consist of the relation to actual people as well as to their representatives in his inner world" (Klein 1985, p.419). Whatever is taking place in their environment, their 'external world', exists in an ongoing, mutually reinforcing interrelationship with their subjective experience and understanding of the latter. It is inevitable therefore that "...emotional and sexual development, object relations and super-ego development interact from the beginning" (ibid, p.419). Throughout infancy and childhood, children face multiple developmental challenges that unless adequately worked through may slow down or even reverse the process of psychological maturation:

At a very early age children become acquainted with reality through the deprivations which it imposes on them. They defend themselves against reality by repudiating it. The fundamental thing, however and the criterion of all later capacity for adaptation to reality, is the degree to which they are able to tolerate the deprivations that result from the Oedipus situation (Klein, 1985, pp.128-129).

To ensure the continuing emotional health of children and young people, parental figures must recognise and respond to both their dependency needs and also their developmental needs for gradual individuation and separation. Psychoanalytic theory emphasises that from earliest childhood feeling 'safe enough' - psychological containment - and the capacity for intimacy are key components for ensuring enduring emotional health. If the baby's projections

are not accepted by their parental – usually maternal – object, s/he will sense “that its feeling that it is dying is stripped of such meaning as it has. It therefore re-introjects, not a fear of dying made tolerable, but a nameless dread” (Bion, 1962b, p.116). Developing children need to experience both maternal containment, with its qualities of empathy, sensitivity and compassion; and also paternal containment, relating more to boundaries and to structure.

During latency the self-absorbed, greedy intensity of infantile feelings abates as children “...learn to feel, for other people who help them in their helplessness and satisfy their needs, a love which is on the model of, and a continuation of, their relation as sucklings to their nursing mother” (Freud, 1998, p.34). As puberty approaches, however, children face another major developmental challenge, that of separation and individuation from parental adults, in preparation for eventually assuming responsibility for themselves. Freud (1998, p.39) highlights the difficulties children face as they struggle to complete “...one of the most painful, psychical achievements of the pubertal period... detachment from parental authority...” Loss and mourning, as well as excitement, hope and triumph are all entailed in this challenging developmental stage, during which a critical task for parental adults “...is to move the child into a position from which it can separate from its parents and look after itself” (Stokoe, 2003, p.89).

Puberty heralds adolescence, which after the relative quiet of the latency period, confronts young people with a period reminiscent of infancy in its turbulent, frequently painful and occasionally violent, emotionality. The Latin root of aggression, meaning ‘to move towards’ (Music, 2009, p.154) encapsulates the energy and agency that fuel the ‘roller coaster’ of adolescence. At the same time, the rapid changes and flux that are part of adolescence inevitably arouse significant anxiety. This explosive, at times frightening, emotional mix is captured in the language selected by several psychoanalytic writers. Blos (1998, p.82) refers to the “...violent rupture with childhood and family continuities.” Winnicott (1986, pp.158-159, italics) claims “If the child is to become adult, then this move is achieved over the dead body of an adult.” While Upson (1991, pp. 51-52, italics in original) comments on the “life and death issues [which] are around quite literally in

adolescence...adolescents are both tremendously stimulated and excited by this feeling of power and control over life and death matters and, *at the same time*, absolutely terrified of it". Adolescence is a time of wide and rapid mood changes and great ambivalence as young people simultaneously look forwards towards imagined greater independence and backwards towards the security of parental ties (Alfille-Cook, 2009, p.62). When adolescent turbulence is successfully negotiated, individuality and creativity are fostered, but these may be stymied by overwhelming feelings of infantile rage or unresolved loss. The intense pain accompanying such feelings is defended against by a variety of unconscious defences, among which the paranoid-schizoid mechanisms of denial, splitting and projection take on a similar prominence during this transitional process to that of infancy.

"In every adult, traits not only from the little child but also from the adolescent persist" (Lampl-de Groot, 1998, p.71). Bion and the post Kleinians emphasise that not only during childhood and adolescence but also throughout our lives we oscillate between paranoid-schizoid and depressive positions and repeatedly face major developmental challenges. Adolescence is, therefore, both a developmental stage and also a state of mind that can be re-evoked at any time: "if we are talking about adolescence we are talking about adults because no adults are all the time adult" (Winnicott, 1986, p.81). (I revisit this latter aspect in chapter 5 when I discuss feelings evoked in those who work with adolescents.)

## **Section 1. External worlds: childhood deprivation, abuse and multiple dislocations**

"An emotional experience cannot be conceived of in isolation from a relationship" (Bion, 1962a, p.42).

Parental adults both constitute and provide the child's earliest environment. In this section I discuss my first theme, which I have named 'external worlds: childhood deprivation, abuse and multiple dislocations', with its three sub-themes, which together cover experiences of: parental ineffectiveness,

inconsistency and neglect; direct and indirect parental violence; and finally that of being a 'looked after child' whose perceived degree of disturbance triggers a referral to CAMHS. In so doing, I describe the particularly adverse combination of circumstances defining and constraining the life circumstances of a category of young people who have been aptly described by Darra Singh, chairman of the independent 'Riots, Communities and Victims Panel' (cited in Higginson, 2012, p.1) as "bumping along the bottom", at the interface between safeguarding and mental health and to which belong Kerie and Dermot, the two young subjects of my reflective case studies.

To the extent that young children's experiences of the people populating their external worlds, most importantly their mothers and other parental figures, are predominantly benign, they will build up internal worlds which are on the whole peaceful, secure and conducive to integrative processes. If, on the other hand, their external worlds provide them mainly with experiences of tension, confusion and distress, infants and young children will build up inner worlds correspondingly anxious, ambivalent and untrustworthy. "Unpleasant experiences and the lack of enjoyable ones, in the young child, especially lack of happy and close contact with loved people, increase ambivalence, diminish trust and hope and confirm anxieties about inner annihilation and external persecution" (Klein, 1985, p.347). Kerie and Dermot, like most of the young adolescents whose state of mind/mental health needs assessments I have undertaken, had experienced since infancy accumulative experiences of deprivation, abuse and catastrophic loss. I group the formative early life experiences of these young people into a number of overlapping sub-themes.

### **1.1 The experience of parental ineffectiveness, inconsistency and neglect**

The most inclusive category of disadvantage and vulnerability relates to children and young people whose parents, because of chronically adverse circumstances, are severely compromised in their capacity to consistently provide 'good enough' parenting. On the basis of extensive research on children living in poverty or with long-term parental ill health, Pollak (2010) concludes that, when exposed to chronic stress, the whole family system

suffers no matter how hard parents try to shield their children. He argues that, regardless of what is 'hard wired' in the human brain, our development is modulated by social relations. Both Kerie and Dermot were born into materially disadvantaged, peripatetic families. In addition, Kerie's mother was clinically depressed during her daughter's infancy. As young children their home environments were chaotic. Neither set of parents could provide the reasonably consistent and stress free family environment conducive to all round development (Music, 2009).

In addition, Kerie and Dermot were chronically neglected. Each set of parents struggled unsuccessfully under the impact of: domestic violence (both families); depression (Kerie's mother) or substance misuse (Dermot's parents). Kerie, as the oldest sibling, was expected from a very young age to take on childcare responsibilities. She became extremely competitive with and envious of her younger siblings, to whom she also behaved alternately in either a dismissive or parentified way, when confronted with her mother's inappropriate expectations that she often look after them. Dermot was also intermittently a young carer, in his case for his parents when they were incapacitated through alcohol misuse. His defensive response was to develop a precociously 'mature' and brittle self-reliant persona, a type of second skin defence (Bick, 1986). Social care professionals were involved in both families for several years though with little apparent impact.

## **1.2 The experience of direct and indirect parental violence**

"The association between child abuse and neglect and parental problems, such as poor mental health, domestic violence and substance misuse, is well established" (Munro, 2011, p.7). Children who experience accumulative abuse, whether physical, emotional or sexual, feel under constant threat. Kerie's teenage mother left her father while pregnant with Kerie because of his violence. She continued, however, to become involved with abusive men, by whom she had several more children. Not only was Kerie exposed to chronic domestic violence from conception, but also by the time she was taken into care she had been physically and/or sexually abused by a number of 'father figures'

from whom her mother had failed to protect her, even after Kerie had disclosed the abuse to her. Moreover, she displaced onto Kerie her own sense of hopelessness and fear, derived from her relationships with violent, predatory men, and blamed her very young daughter for giving vent to helpless distress and rage through uncontrolled behaviour. As a result, Kerie developed a lasting sense of guilt that she was to blame for most of what went wrong in her family.

Professional agencies, including children's services, the police and later CAMHS, were involved with Kerie's family from her infancy because of domestic violence and parental neglect. Similarly, children's services had a history of involvement with Dermot's family because of domestic violence, chronic neglect and physical and emotional abuse. Although, unlike Kerie, he never disclosed being sexually abused to professionals, after he came into care the professional network came increasingly to believe that his close, ongoing relationship with a middle-aged man, a longstanding 'family friend', was sexual in nature. Dermot was aware of these suspicions, which he consistently refuted while placed at Norfolk House. However, his contention that he couldn't wait to leave the home in order to live with this man; the latter's failure to engage with social services; and Dermot's unaccounted for disappearances for several days at a time, stoked professional anxiety about this man's possibly predatory intentions toward Dermot.

### **1.3 The experience of being a 'looked after child' whose perceived degree of disturbance triggers a referral to CAMHS**

Kerie and Dermot both belong to the category of children and younger adolescents who, as a result of damaging early experiences, become LAC. Such children are already vulnerable to developing mental health problems by the time they enter the care system (Mental Health Foundation, 2002). Major risk factors associated with childhood psychiatric disorders include: social and environmental factors, parental psychopathology, repeated early separations from parents, harsh or inadequate parenting, exposure to abuse or neglect and adverse peer group influences, all of which, with the possible exception of the

last, characterise both Kerie's and Dermot's home situations (Office for National Statistics, 2004, cited in McAuley and Young, 2006, p.92).

Most children and younger adolescents enter care via one of two routes: either the local authority pursues Care Proceedings to remove the child from their birth parents, as with Kerie; or else it enters into a voluntary but formal agreement, which recognises that the birth parents cannot, for whatever reason/s, adequately care for their child, as with Dermot's birth parents. Either entry route strips the young person of any remaining expectations of being adequately parented by their birth parents. According to Winnicott (1986, p.159, italics in original) "...the best [parents] can do is to *survive*, to survive intact, and without changing colour, without relinquishment of any important principle." While continuing to have limited contact with their children after the latter entered care, neither Kerie's nor Dermot's parents 'survived intact' in the sense meant by Winnicott. Even before they entered the care system Kerie and Dermot had been emotionally abandoned both by their actual and also by their idealised internal parental figures, who had become "...empty of life, neither interested or interesting" (Music, 2009, p.144). Depression rendered Kerie's mother emotionally absent from before her birth. And although Dermot's parents remained together until their eviction from the family home, an event triggering the family's physical dispersal and precipitating him into a 'hand to mouth' peripatetic lifestyle for almost two years, entry into care was only the formal acknowledgement of his accumulative privation and deprivation. Even so, both Kerie and Dermot experienced the formal rupture with their birth families, embodied by coming into care, as a kind of expulsion. Kerie never tired of trying to convince professionals to let her live with her mother, although the latter, to my knowledge, never supported, let alone actively encouraged, this plan. Dermot showed his bitter distress indirectly through transferring onto his relationship with professionals a strong sense of slight and grievance about being excluded and marginalised. When his family became scattered after their eviction, his mother had apparently prioritised her relationship with a man - not Dermot's father - over her responsibility for Dermot and his siblings. Both young people demonstrated disorganised attachment behaviour<sup>4</sup> towards their

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<sup>4</sup>**Attachment theory**, with roots in psychoanalysis, psychiatry, evolutionary theory and ethology, is popular internationally as an explanatory framework among social care and mental

mothers. Neither ever brought up their birth fathers with me nor, as far as I am aware, with other professionals. Both young people seemed determined, at a conscious level of awareness, to wipe out their thoughts and feelings about these men:

Children in care manifest complex psychopathology, characterized by attachment difficulties, relationship insecurity, sexual behaviour, trauma-related anxiety, conduct problems and defiance, and inattention/hyperactivity, as well as uncommon problems such as self-injury and food maintenance behaviours (Tarren-Sweeney, 2008, p.346).

Because of their pronounced and visible level of disturbance, many of these children and young people are referred by social care to CAMHS. Access is generally through specialist CAMHS teams established to work in partnership with the local children's services in order to offer a targeted service to LAC, their carers and their wider professional support networks. In 1999, the Audit Commission noted that the regular clinical population of these specialist CAMHS were young people with multiple problems and frequent co-morbidity. This finding is predictable in view of the many and various psychosocial hazards they have experienced, often since infancy, and are likely to continue facing even after entering the care system. Kerie's family had been referred to CAMHS for family therapy when she was a toddler. Some years later, while placed in a children's home outside London, she was referred to a local CAMHS. I am unaware of any contact that Dermot and/or his family might have had with CAMHS before he was referred to IAT during his placement at Norfolk House.

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health professionals. While initially emphasising spatial proximity to the care-giver, attachment theory has become increasingly sensitive to both the emotional quality of the relationship between young child and primary carer; and also to the parental state of mind. Bowlby (1961), its first exponent, referred to the "representational models of attachment figures" that children develop, which consequently predict, their relationships with parental figures and later more generally. Ainsworth (1978) and others increasingly differentiated between several specific attachment patterns that very young children gradually develop towards their primary caregivers, distinguishing not only between secure and insecure attachment behaviour but also, within the insecure category, between anxious-avoidant and anxious-ambivalent forms of attachment. Subsequent research has identified another sub-category of insecure attachment behaviour, i.e. disorganised, in which children erratically combine elements of both avoidant and ambivalent behaviour.

## **Section 2. Internal worlds: the devastating psychological impact of severely adverse formative experiences**

My second theme, which I have named ‘internal worlds: the devastating psychological impact of severely adverse formative experiences’, relates to the impact that overwhelmingly painful early childhood experiences have on young people’s subjective reality. In order to explore in detail the serious psychosocial difficulties that correlate closely with childhood deprivation and abuse, I have identified four sub-themes: ‘spilling over’; ‘not enough to go around’; ‘a very short fuse’; and ‘confusion reigns’. I discuss each sub-theme in turn, using material from my reflective case studies of Kerie and Dermot.

### **2.1 Spilling over**

“Anxiety in children is originally nothing other than an expression of the fact that they are feeling the loss of the person they love” (Freud, 1998, p. 35).

I have chosen the term ‘spilling over’ to capture the quality of feeling engulfed by uncontainable and hopeless anxiety, misery and rage originating from repeated experiences of loss. Among the most significant developmental challenges that children and young people can experience is the loss of benign external and internal parental figures. This may result from their physical absence; or from their emotional distance caused, for example, by post-natal depression (as experienced by Kerie’s mother) or from chronic neglect and/or active abuse. Bowlby (1979, p.45) refers to evidence of a “...causal relationship between loss of maternal care in the early years and disturbed personality development.” Children need consistently loving parental figures to whom they can securely attach. The loss of this relationship, whether in a physical or a psychological sense, is experienced as catastrophic and leads to a process akin to unresolved mourning or ‘melancholia’ (Freud, 1917) for the ‘death’ of the idealised parental figure. How can children successfully negotiate separation and individuation if their relationships with their parents are insecure and/or prematurely ruptured? They are exposed, instead, to unresolved distress, anxiety, anger and an ensuing sense of guilt, which they may either direct

outwards, turning violently against others, or else inwards, resulting in self-harm and/or risk taking behaviour. According to Klein (1985, p.354) “The greatest danger for the mourner comes from the turning of his hatred against the lost loved person himself...his death, however shattering for other reasons, is to some extent also felt as a victory, and gives rise to triumph, and therefore all the more to guilt.” Kerie’s paternal figures were actively malign while her mother either turned a blind eye towards or, alternatively, blamed her very young child for the latter’s painful, chaotic and angry feelings which erupted at times into violent outbursts directed both towards others and against herself. Dermot had also been exposed to a chronic and toxic combination of neglect and abuse from early childhood. In a very real sense both young people were emotional orphans:

Emotionally deprived children are traumatised at a stage so early that they cannot realize, symbolize or conceptualize what has happened to them: they 'remember' only through feeling. There is no way of containing traumata. This is how I understand the aetiology of panic states and the violence which springs from them (Dockar-Drysdale, 1993, p.126).

Both Kerie and Dermot experienced almost unthinkable recurrent and accumulative trauma from a time before they could verbalise and are therefore only retained as procedural memories. Because they lacked parental help in recognising and thinking about painful emotions, they tended to experience them instead as physiological states, for Kerie enuresis and psoriasis and for Dermot’s sleep difficulties and headaches.

And because they were very poorly equipped to cope with even the minor vicissitudes of life inevitably encountered on a daily basis, they instinctively bypassed thinking in order to evacuate and/or pass on their intolerable distress and frustration. Rustin (2001, p.274) writing about her work with two young ‘looked after’ boys refers to “the intolerable feelings which their way of life was designed to hold at bay”. Whenever Kerie’s anxiety escalated, she was inclined to spin off into a heady mixture of excitement and fearfulness, in which mood threats and abusive language could spill over into physical violence. When I visited her, for example, soon after her transfer from Norfolk House to a three-bed specialist adolescent unit, she initially painted an idealised picture of her life in the new unit. She then abruptly pulled up her sleeve to reveal deliberate cuts on her arm and began speaking in an increasingly desperate and defiant way

about how she wanted to have a baby with a young man she had only just met, on one of the many occasions she had already absconded from this semi-secure unit. Declaring that 'we' - parental adults, her professional support network and, by extension, the adult world generally - could not stop her, she turned away from me dismissively, leaving me filled with helpless anxiety. Dermot tended similarly to reveal the extent of his underlying anxiety by becoming verbally contemptuous and occasionally threatening. For example, his manner towards his social worker - on whom he chiefly relied for his basic practical needs, as well as being the person charged by the local authority with negotiating whether or not he could/should return home - was overtly bombastic and bullying. He demanded that she provide him with all manner of material 'goodies' and was likely to become verbally abusive if/when she did not accede. I felt that by indirectly demonstrating his anxious dependency on his social worker, Dermot was re-enacting with her, as a substitute maternal figure, his painfully ambivalent, insecure, possibly disorganised, attachment relationship to his withholding, neglectful and emotionally abusive birth mother.

## **2.2 Not enough to go around**

A second significant aspect of the impact of harsh external reality on young people's internal worlds is the sense of privation, deprivation and exclusion engendered a feeling that there is never enough to go around, of always missing out and having to make do. This feeling is very likely, in turn, to lead to resentment, sibling rivalry and a pervasive sense of grudge. If young people's needs for both maternal containment, with its emphasis on compassion and empathy; and also paternal containment, relating to boundaries and structure, are not adequately met, it becomes highly likely that they will develop a notion of the world as one "...that did not want to know...and did not want to be known" (Britton, 1992, p.107). Neither Kerie's nor Dermot's parents were able to provide an adequate level of emotional containment. As a result both young people lacked confidence that parental adults could/would 'hold them in mind' without needing to be continually prodded emotionally and sometimes literally. Kerie's mother complained that from early childhood Kerie had been

uncontrollable while Dermot's reception into care was triggered by a physical fight with his mother.

Kerie communicated a bitter sense of deprivation, tinged with grievance and a deep lack of trust in adults. Any failure to respond immediately to her demands could trigger a violently punitive reaction. Her strong sense of being marginalised and overlooked led her into self defeating, at times dangerous, perverse and/or delinquent methods of attention seeking, including highly risk taking behaviour, self-harm, promiscuity, vandalism and theft. Dermot also felt persistently 'short changed' by professionals, including his social worker and the RCWs, whom he accused of being withholding. Workers were 'stingy' and Norfolk House was 'a dump'. "The staff of children's homes are especially vulnerable to being treated with contemptuous indifference...they are made to feel very fully what it is like to be ignored, despised, helpless or even unreal and non-existent" (Hoxter, 1983, p.128). My counter-transference feelings were that both Kerie and Dermot projected into most members of their professional support networks, for most of the time - myself included - a sense of an incompetent and/or deliberately withholding parental figure. Ordinarily, as children begin to assume their own separate identities, they question their early, internalised images of almost perfect, generous, omnipotent and omniscient parental figures. This may, in turn, generate a degree of caution, suspicion, even hostility, towards future offers of support and guidance from parental adults, expressed for example in adolescent 'stoppyness' and omnipotence. How much more powerful are these tendencies likely to be in young people such as Kerie and Dermot who never had the opportunity when very young to ruthlessly test out and internalise, through repeated 'use and abuse', the experience of basically benign 'good enough' parental figures.

Both young people were desperately keen to remain in touch with their mothers in spite of the apparent lack of reciprocal feelings. Kerie frequently phoned her mother and consistently pleaded with her social worker and the IRO to be allowed to visit her and ultimately return 'home' to her mother and younger siblings. She pleaded that she was a 'reformed character' and could not understand why, since her mother was looking after the younger children, she could/would not also accept Kerie. For Dermot, staying in touch with his mother

was relatively simple as she lived 'around the corner'. He frequently 'dropped by', even though not made to feel particularly welcome by her. Neither mother seemed to envisage, let alone welcome, the possibility of their child returning home. Sprince (2002, p.154), noting that "Children who have been abused, neglected and abandoned do not cease to love their parents or to feel profoundly loyal to them", highlights their extremely painful predicament:

When they can allow themselves to receive love and understanding from others, instead of fighting it off, they are confronted with a stark contrast. They are forced to recognize the terrible shortcomings of the parents they love, who have shaped their characters, and in whom they have invested so much of their sense of identity and meaning.

### **2.3 A very short fuse**

My third sub-theme is intolerance of frustration, combined with extreme emotional volatility, oscillating between neediness and a stance of prickly self-sufficiency. Although each young person demonstrated both states of mind at different times, Kerie veered more towards the former and Dermot towards the latter. Her attachment pattern combined disorganised with anxious ambivalent traits while his was oriented towards anxious avoidant. Both engaged with professionals in largely superficial and instrumental ways. Kerie was often clingy and demanding, whereas Dermot mainly kept his distance. At any one time a very limited number of workers might provisionally and temporarily be, in his opinion, 'O.K.'. Everyone else was deemed to be incompetent, if not worse. Both young people, however, shared the characteristic of volatility. Kerie could swing rapidly from ingratiation to angry rejection; while Dermot might radically demote any individual worker at short notice from the pedestal on which he had temporarily placed her/him.

Young people need paternal as well as maternal containment, i.e. they need to be set consistent and non-punitive boundaries and limits. Both Kerie and Dermot came into care because they were 'beyond parental care and control' which implies that their birth parents had been unable or unwilling to maintain essential limits to their behaviour. It is unsurprising, therefore, that like so many adolescents in care they had never had an opportunity to internalise a benign boundary setting function which would facilitate emotional regulation. Because

neither Kerie nor Dermot had received 'good enough' emotional containment as young children, their capacity to tolerate frustration was severely compromised. This, in turn, made it very difficult for them to be reflective. "Inability to tolerate frustration can obstruct the development of thoughts and a capacity to think" (Bion, 1967, p.113). Instead, they tended to evacuate unwanted feelings through impulsive and erratic behaviour, a manifestation of their tendency to swing frequently and rapidly between manic elation and depression.

Although he had been effectively homeless for the two previous years, Dermot did not come into care until the age of fourteen, by which time he had assumed a protective carapace of precocious maturity and self-sufficiency (one of the defences I discuss in section 3). This, however, could easily crack to reveal the extent of his dependency needs. Sometimes when I talked with Dermot, although, or perhaps because, he seemed so keen to give me an impression that he was able to look after himself, I found myself feeling anxiously and impotently protective towards him. On one occasion, when I was visiting Norfolk House in the early evening, he told me with emphasis that he intended to make his own supper. He added, rather poignantly, that while 'on the road' he had mainly eaten 'sausages and mash' but that now he wanted to eat healthily. I noticed a little later, that instead of making his own meal, he had joined in and was apparently 'lapping up' the relaxed domestic environment created by two female staff members as they prepared and ate supper for and with the young residents, including Dermot.

Kerie's self-presentation was different from Dermot's. She tried to present herself as calm, amenable, and thoughtful when 'negotiating' with adults (another self-protective defence). An example occurred when, in a LAC review I attended, she put forward her case for being allowed to return home. Towards the end of the review, however, her apparently confident but ultimately extremely fragile self-presentation collapsed. The emotional cost to her of keeping up this blandly positive and 'sensible' presentation was too high. Eventually, succumbing to a storm of pent up rage, mixed in with helpless distress, she ran from the room in tears. The following day I witnessed the aftermath of the effort it had taken her to argue her case coherently. She largely initiated and then escalated a serious and prolonged incident at Norfolk House

involving two other girls, in which she was in turn bullying and bullied, both verbally and physically. The extremely provocative and risk taking behaviour Kerie demonstrated on this and other occasions might be understood in part as a desperate need/plea for adults to put in place around her the protective and limit setting boundaries that her mother had been unable to impose when she was a very young child and which, therefore, Kerie had never had the opportunity to internalise. **Confusion reigns**

“...a sense of reality matters to the individual in the way that food, drink, air and excretion of waste products matter” (Bion, 1962a, p. 42).

I call my fourth sub-theme ‘confusion reigns’ in order to convey a sense of the uncertainty, elusiveness, muddle and occasional chaos that young people like Kerie and Dermot, whose lives have been so fragmented, can generate both internally and also within and between those who support them. Youell (2002b, p.125) considers that one reason for the discrepancy that may arise between the perspectives of different professionals towards such children is that the presentation of the latter:

...is genuinely confusing. These are children who have been repeatedly traumatized...from a very early age...In Bick's terms, they do not have the experience of being held together by the primal skin container, something she describes as being dependent on experience of an external object capable of fulfilling this function.

One significant source of uncertainty and confusion for young people like Kerie and Dermot is that, for reasons already outlined, they are likely to feel fear and hostility towards their parents while at the same time seeking their love and care:

...a sense of truth is experienced if the view of an object which is hated can be conjoined to a view of the same object when it is loved and the conjunction confirms that the object experienced by different emotions is the same object (Bion 1967, p.119).

Nether Kerie nor Dermot could achieve an ordinarily ambivalent and integrated sense of their parents. The intensity of their need for, but also lack of confidence in, their mothers pushed them into radically split perceptions of their ‘maternal objects’. During our sessions Kerie never explicitly articulated any hatred toward her mother. She always spoke about her family in rather bland,

vague and idealised terms, full of inconsistencies and omissions; her 'truth' seemed to have an extremely elusive quality. Through my counter-transference, however, I frequently experienced what I understood as her hostility and mistrust towards maternal figures. At such times I would find myself filled with anxious and turbulent feelings including frustration that, although apparently craving adult attention, when this was offered to her Kerie would reject the opportunity, leaving me with a sense of being deskilled and useless.

During one of our sessions Dermot drew what looked like a vertical blade, next to which he wrote, "*die mum die*", before abruptly leaving the room. My understanding of this sequence was that, by leaving the room, he was trying to protect me, a substitute maternal object, from the brunt of his murderous rage against his mother, to whom he simultaneously needed to stay close. During another of our sessions, he had a sudden urge to phone her and say that he would visit her that evening. She apparently said something he didn't want to hear, possibly that this would not be convenient. The phone call ended abruptly and he told me, with mixed defiance, anger and distress that her response had been typical but that he saw her a couple of times each week. (To my knowledge neither she nor his father ever visited Dermot at Norfolk House during the approximately two years he was placed there.) Camila Batmanghelidjh, chief executive of Kids Company (cited in Cohen, 2013c, p.8) describes the adolescents she works with, many of whom have had similar developmental experiences to those of Kerie and Dermot:

It's like they've swallowed a helicopter with the propeller turning. They are in a constant hyper-aroused disturbed state. Often they have mental health problems that need addressing. They can't fall asleep, they have nightmares, they cry in their sleep, scream, wet their beds. When they wake up, it's like a truck has driven over them because all night they've been at war.

Both young people were caught in a desperately frustrating repetitive pattern, both for them personally and also for those wanting to support them, of seeking an almost intrusive intimacy - as if wanting to climb inside their maternal objects - before quite suddenly withdrawing in a hostile and rejecting manner. This common, if not universal, developmental tension, described by Rey (1988, p.218) as the 'claustro-agoraphobic dilemma' and by Glasser (1992, p.124) as the 'core complex', can sometimes take 'centre stage' during adolescence. It is

particularly poignant and painful for young people like Kerie and Dermot who have been rejected by their birth parents

The pain, confusion and fear that can be stirred up in some young people when they are abandoned, both by their actual and by their idealised internal parental figures, can trigger panic states and even violent outbursts. Because of the unpredictable, confusing and traumatising parenting they had received, Kerie and Dermot had both developed traits indicative of disorganised attachment. They were erratic, restless, inconsistent and hyper-alert; they demonstrated, inter alia, both helpless and hostile behaviours; and they both engaged in risk taking and dangerous activities (Music, 2011, p.69). Any failure, for example to respond immediately to Kerie's demands, might trigger a punitive and violent retaliation, which, in a confused and confusing way, seemed to be aimed as much against herself as against others. For instance, on one occasion she threatened to throw herself off a roof after a standoff arising from a quarrel with two other young residents at Norfolk House. This escalated into almost a state of siege, involving most of the staff on shift. Kerie's threatening message to the world seemed to be 'watch out - someone will be punished'. In the event, as her threats rebounded on the most vulnerable person, 'someone' was likely to be Kerie. (I return to this theme in section 3 when I discuss forms of 'ganging up', in one of which the victim is a vulnerable part of the self, cowed by a bullying internal mafia.)

As a result of a terrifying mix of inappropriate maternal expectations, neglect and abuse, Kerie had gradually internalised an extremely negative view of herself as a failure and a troublemaker. Alongside this, her hold on reality was slippery. One evening at Norfolk House, for example, she kicked a female residential care worker and then immediately accused the latter of having hurt her; while on another occasion she alleged in the face of the evidence that a male staff member had just physically abused her. Neither I nor other professionals felt able to determine whether, on such occasions, she was deliberately lying or was profoundly confused. As a residential care worker expressed it, "*She doesn't even understand that she is lying, it just comes out*". I tended to understand Kerie's tenuous and brittle hold on reality as being both the result of a psychological condition similar to 'accumulative post traumatic

stress disorder', brought about by chronic neglect and abuse, including sexual abuse; and also a type of 'psychic retreat' (Steiner, 1993a) against unbearable pain. (I return later to the concept of psychic retreat.)

One type of confusion sometimes experienced by children and young people who have been sexually abused is that between intimate and sexualised behaviour and relationships. An RCW articulated the connection between Kerie's disturbed behaviour and sexual abuse:

*It became so evident that this child was so distressed and obviously sexual things had happened when she went missing and everything and we had defecating and urination in the corner, lining up cups of urine... That was her signal to say something sexual has happened to me (RCW focus group, April 2013).*

As a young child still living at home, Kerie had informed her mother that her stepfather had sexually abused her. Her mother's response that she was either mistaken or lying must have been terribly undermining for Kerie. Was she to trust her own memory and feelings or go along with the version of reality offered by her mother? Unable to rely on the latter - who she loved and on whom she totally depended - to confirm her sense of reality, Kerie was in deep emotional trouble. Having internalised her mother's projection of her own guilty complicity in eroticised violence, Kerie later re-enacted with conviction the part of a dangerous and sexually promiscuous young girl, becoming involved at Norfolk House in several incidents of sexualised risk taking activities with both male and female peers. I wondered whether she found it difficult to differentiate between intimacy and a sexualised relationship. If so, perhaps for her these sexual overtures were attempts to make emotional contact.

Soon after being placed at Norfolk House, Kerie disclosed that a male staff member at her previous residential placement had behaved towards her in a sexually inappropriate manner. I became aware that male members of staff at Norfolk House were apprehensive that she might at any time make an allegation against one of them. This disquiet, amounting almost to a sense of threat, became heightened, and to some extent distracting professional attention from her significant sexual vulnerability, when she began to insist on calling a senior male worker 'daddy'. It was unclear whether she was being extremely needy and/or disingenuous. However, male staff members especially

were concerned about what they perceived to be an element of veiled menace. This impression, in turn, exerted a considerable negative influence on staff attitudes towards a very vulnerable twelve year old who came to be seen as sexually dangerous. Dermot, on the other hand, was perceived initially by professionals not as sexually dangerous but as extremely vulnerable to sexual exploitation. As such he elicited their anxiously protective feelings. Gradually, however, staff attitudes towards him at Norfolk House and elsewhere in the professional support network became increasingly skeptical and 'laissez faire'.

### **Section 3. Minds like minefields: survival tactics in a world shot to pieces**

The name I have given my third theme is borrowed from Sprince (2002) to indicate the impact on young people like Kerie and Dermot of being battered by a continuous painful emotional barrage. There are multiple ways of erecting defensive barriers against the overwhelming pain of accumulative damaging experiences, three of which I focus on in this section. I call them respectively: keeping on the move, taking cover and fighting back.

Sprince (2002, p.148) observes that LAC children in residential placements (as for example Norfolk House):

...have been through so many damaging experiences that they have lost hope...Their minds are like minefields: at any moment something may trigger a memory of terrible pain and humiliation. So they retreat into a mindless, unthinking way of getting through the day. When a painful feeling threatens to erupt, they look for any way of escaping from it: this can be through sex, violence, drugs, drink or a myriad other forms of delinquency.

Unbearable distress, anger and confusion may be violently evacuated and/or projected into others, the young person for example, becoming involved in manic acting out, either alone or by ganging up with others. Alternatively, s/he may turn inwards, attempting to become immune from emotional pain by dulling thought and feeling through addictive and highly risk taking activities such as promiscuous sex, substance abuse and/or deliberate self-harm. Each of these flight paths originates from a totally understandable impulse of self-protection

against overwhelming emotional pain. "Defences are never there for nothing. The bigger the defence, the more sure one may be of the need for it" (Main, 1989, p.215). However, these overlapping, primitive coping mechanisms tend gradually to become increasingly perverse. And as they are never more than very partially and temporarily successful in their original aim of distraction, they are revisited over and over again with increasing desperation. Both Kerie and Dermot perceived their worlds as unstable, discontinuous and in tatters. Anticipating disappointment, danger and treachery in their encounters with subjective reality, they sought to defend themselves at different times by keeping on the move, taking cover or fighting back.

### **3.1 Keeping on the move**

In an attempt to cope with their chaotic, highly unpredictable, at times dangerous family environments, young people like Kerie and Dermot are likely to develop defensive strategies such as hyper-vigilance, continuous activity and a quality of always being 'on the edge of the chair', ready to 'jump before being pushed'. Bick (1964,1986) describes 'second skin' defensive modes of functioning, which some children develop in order to protect themselves against intolerable emotional intrusion. Although appropriate coping strategies in volatile and threatening early home environments, they can become highly dysfunctional when transferred to other contexts or generalised. During my meetings with Kerie, she was restless, hyper-alert, always on edge and prone to swing between states of intrusive curiosity combined with nervous excitement and those in which she presented as flat, bored and dejected. She frequently left the meeting room, sometimes returning after a few minutes, at other times abandoning me entirely for the rest of that session, having successfully projected into me her feelings of being redundant, unwanted and excluded. During one of our sessions she spent almost the whole time playing a computer game in which a tiny and solitary cartoon character was journeying along a desolate and hazardous route, struggling to survive and overcome any number of vicious mortal enemies and overwhelming obstacles. Kerie's recourse to manic omnipotence as protection against an underlying sense of loneliness and mortal fear in confronting the immensely violent scenario, portrayed through her

role-play, struck me as a vivid and accurate representation of her internal world. I was both stunned by the level of violence and also flooded by feelings of hopelessness and helpless despair. The session ended, as they usually did, with Kerie abruptly fleeing from the room, abandoning me to process both her and my own emotional turmoil.

Though less extreme, Dermot's presentation in our meetings suggested that he too was forever about to take flight. Although we met several times and he seemed to value these sessions, he could abruptly 'cut out' emotionally and cognitively at any point in a session, leaving me feeling that the potential thinking space which I offered, and which he sometimes seemed to welcome, no longer held any attraction for him. At such times I sensed that he perceived thinking to be rather dangerous and as such to be avoided and evaded. There were, however, times when he was sufficiently focused to be able to create detailed drawings. These were mostly scenes of manic jauntiness and constant activity, for example depictions of a circus ring and of escalators endlessly rising and descending. Occasionally, however, he sketched scenarios of empty, impenetrable, windowless buildings that struck me as depicting his underlying feelings of loneliness, abandonment and desolation. Like Kerie, his mood could switch at very short notice from manic energy, verging on bluster and omnipotence, to depressed silence. His preferred settings for our meetings were informal, transitional spaces, such as the utility room or the corridor leading to a side door of Norfolk House. I sensed he needed to feel in control of his 'escape routes'.

During our sessions, as well as in their general presentation toward professionals, both young people seemed simultaneously to want the attention of a benign parental figure and also to distrust and therefore need to preemptively reject that contact. While desperately wanting their dependency needs to be recognised and met, both experienced an equally strong defensive impulse to jump before being pushed (away). In this way they could retain the magical illusion that ultimately they were choosing to reject rather than being rejected. Several times, having indicated that she wanted to meet with me, Kerie refused to see me when I had made myself available. While often intrusively curious, she was adamant that she didn't want to know what I had written in her

state of mind assessment report because it would be 'boring'. In a similar manner, having told residential staff that he wanted to see me, Dermot refused to get out of bed for a 5pm appointment with me to discuss his assessment report.

I attended both Kerie's and Dermot's LAC reviews. On each occasion the young person initially presented in a way that seemed, consciously or unconsciously, directed towards eliciting a sympathetic response to their vulnerability and dependency needs. Kerie clutched a cushion, as though for comfort and protection, throughout her meeting. Dermot came into the room for his review wrapped in a duvet and immediately slumped on a sofa, looking the epitome of despondency and desolation. On each occasion, however, the meeting ended with the young person making angry and dismissive comments towards those professionals present before summarily leaving the room - Kerie in tears, Dermot using abusive language. Experiencing Dermot lashing out verbally at professionals, both present and absent, and making extravagant demands for money and electronic equipment, I felt that his apparent contempt and grandiosity were barely veiled expressions of his understandable and to some extent justified despair that the adult world could not/would not identify, let alone attend to, his needs. In what seemed like a self fulfilling prophecy, I could sense all the adults in the room, including myself, recoiling almost physically from Dermot's personalised and vitriolic attacks, targeted at one worker after another; and reacting defensively and concretely to the form and content rather than to the underlying meaning of what he was communicating. Afterwards, everyone, including Dermot, seemed to be rather shell shocked. Whatever other meanings his words and behaviour carried, they were clearly intended as a way of jumping before being pushed.

When I spoke with Dermot after this meeting, I felt relieved that I had, at least temporarily, avoided being a target for his angry complaints and accusations; and that he seemed willing to meet me the following day to discuss my report. I was, however, aware of the danger of colluding with his habitual and volatile splitting between 'good' and 'bad' workers. I also sensed an element of persecutory need to check what I had written about him. In the event, my feelings of slightly triumphant relief were short lived! Having been brought back

by the police very early that morning, he refused to leave his bed for our 5pm appointment. I offered another session the following week but when I arrived at Norfolk House I discovered that he had left the home without permission earlier that day and was still AWOL. It was now my turn to feel diminished, deprived and dropped! When he eventually made himself available to meet with me to discuss what I had written in my report, I asked if he would like me to arrange for a counsellor or psychotherapist to continue meeting with him on a regular basis. During our assessment sessions, with the unsurprising exception of the final one, in which he appeared distracted, I had thought he was making effective use of the opportunity to share some of his feelings, mostly painful but some hopeful. I was disappointed when he responded firmly that he didn't want to continue having regular sessions. On reflection, I sensed, through my counter-transference, that this young boy, who had already experienced so many premature and enforced endings, was perhaps feeling rejected by me. He may have experienced me as no longer finding him to be of any interest and trying to rid myself of him by moving him on to another worker. I sensed also that he unconsciously needed me to receive and contain these unwanted feelings that were so corrosive to his fragile self-esteem.

### **3.2 Taking cover**

"If unbearable mental pain is what is mainly shared between mother and infant, a recoiling from contact into mindlessness is an understandable response" (Rance, 1997, p.140). Exposure to what Foster (2002, p.91) calls a 'roller-coaster' of painful emotions may eventually lead a young person to defensively seek emotional anaesthesia, through recourse to various forms and degrees of denial, distancing and detachment, even to the point of frozenness and dissociation. According to psychoanalytic theory, very young children experience their parents' couple relationship as one of threat and rivalry to their own exclusive relationship with their mother. If, for whatever reason or combination of reasons, environmental and/or constitutional, they are unable eventually to come to terms with the existence of a rival for their mother's attention and to relinquish the exclusivity of the infant mother dyad, they may attempt to ward off this unpalatable 'fact of life' through defensive Oedipal illusions. This is a

manoeuvre which Steiner (1993b, p.129) calls 'turning a blind eye'. The inability or unwillingness to believe in a benign parental relationship inhibits the capacity to imagine and welcome "a space outside the self capable of being observed and thought about", which prototypical reflective space is critical because it "provides the basis for a belief in a secure and stable world" (Britton, 1989, p. 87).

Bereft of this confident belief in a secure and benign world, ordinary developmental qualities such as agency and curiosity may be experienced by such young people as dangerous. Dermot's self-presentation was streetwise, hyper-aware (during our sessions he often reiterated that he noticed everything that was going on around him) and precociously mature. In contrast Kerie, despite her violence and sexual promiscuity, exuded a childlike quality. Her desire, for example, to have a baby felt similar to a much younger child's wish to play with a baby-doll. Her accounts during our sessions tended to be so bland, vague, elusive, sanitised and romanticised, so far removed from what I knew of her history and current situation that they had a quality of denial, bordering on dissociation. I understand this escape into fantasy as her defence against unbearable accumulative experiences of being unwanted and excluded, a form of emotional 'homelessness' that was still being played out. Waddell (1998, pp.135-6) refers to this state of mind as a 'wilderness', within which the young person tries to hide from "internal conflict or any imaginative engagement with the complex matter of growing up".

Defensive manoeuvres against overwhelmingly painful feelings may develop from earliest childhood, for example, the 'good' passive baby who has learnt not to protest against neglect or abuse. "Where there has been early trauma and the immature ego has been overwhelmed...defences are often pre-verbal, pre-representational, centring on the body-self, its traumatization and its survival" (Horne, 2001, p.6). Kerie's psychosomatic symptoms could perhaps be interpreted not only as bodily expressions of how she was emotionally flooded but also as pre-verbal defences against the acceptance of terribly painful feelings. Again, it is possible to interpret both Dermot's substance abuse and Kerie's habitual biting as oral defences against procedural memories of accumulative deprivation. Deprived and depriving parental and family

backgrounds and environments are unable to foster in young people an adequate thinking capacity with which to process their extremely painful feelings. As a result they may seek relief in the distracting physical pain of self-harm and/or through the excitement of highly risk taking activities, solitary or collective. The self-harm and suicide attempts that both Kerie and Dermot inflicted upon themselves might in part be understood as responses to their need to be anaesthetised against overwhelmingly negative emotional experiences. By the time I met Kerie she had been self-harming for several years, including scratching and biting herself, head banging and pulling out her hair. From the age of ten, if not earlier, she had talked to workers of wanting to kill herself. In Norfolk House she habitually picked at the sores caused by her psoriasis until they bled. Before coming into care Dermot had been smoking and drinking heavily, possibly taking drugs, and 'living rough' for some years, a period he spoke of as 'being on the road'. By the age of fourteen, he had overdosed three times. Kerie's behaviour towards her peers had a sadomasochistic quality, in that it seemed deliberately aimed at provoking retaliatory bullying, through, for example an almost incontinent level of lying to and about, and 'grassing up' schoolmates. Dermot also often spoke and acted towards his peers in ways that seemed to be almost deliberately aimed at provoking retribution. I believe he was genuinely unsure about and confused by his homosexual feelings. However, above and beyond this, he seemed determined to provoke the other young people placed at Norfolk House to mock and/or reject him on account of his sexual identity. At times he spoke and acted in ways that significantly unsettled the other young people in the home, preoccupied as they were with their own emergent sexual identities and which seemed calculated to draw down on him their mockery and angry retaliation.

After being placed at Norfolk House, Dermot continued in a modified form his previous peripatetic existence, frequently absconding for days at a time before returning of his own accord. It remained unclear to staff where and how he spent his time during these absences. In a similar way, though less often, Kerie went AWOL for hours or even days, on one occasion being picked up by police fifty miles from London. Sometimes she simply turned up again at Norfolk House, refusing to inform the adults of where she had been and whether she had been alone. It was as if both young people felt the need, almost literally, to

'go to ground' from time to time. Both normally returned of their own accord, leaving me to wonder if there was an element of testing out whether they would be missed, a way of checking the substance of the 'home base' offered by Norfolk House?

Another form of taking cover is to assume a protective false self (which has links with second skin defences) in order to mask turbulent and painful emotions. Dermot frequently sought protection behind a paper-thin mask of haughty self-sufficiency. It is possible that his identity as a young carer, as well as being imposed on him because of his family background, also provided him with a secondary gain in that he was able to persuade himself that he could triumphantly reverse ordinary dependency relationships. Klein (1985, p.351) writes of "the desire to reverse the child parent relationship, to get power over the parents, and to triumph over them". I also experienced Kerie's self-presentation, at those times when she was attempting to persuade professionals that she was sensible and thoughtful, and should therefore be allowed to return home, as a type of false self or perhaps something similar to a psychic retreat in that it contained a quality of superficial accommodation which veiled emotional withdrawal, elusiveness, secrecy and dissociation. Youell (2002a, p.207), in recounting her impressions of a very young child, notes that "viewed from outside the room, her activity might have looked like resourceful, independent play. Sitting in the room, however, I was aware of a terrible emptiness, and, as time went on, felt an urge to give up trying". I picked up similar underlying qualities of remoteness, impenetrability and avoidance in Kerie, both when she was at her most plausible and persuasive and also at those times when she was apparently sociable and energetic.

### **3.3 Fighting back: victims or villains?**

By the time the boy or girl has become hardened because of the failure of the communication...and when secondary gains have become important... then it is much more difficult to see...the SOS that is a sign of hope in the boy of girl who is antisocial (Winnicott, 1986, p.90).

The United Kingdom has one of the lowest ages of criminal responsibility in the world, lower than, for example, China or Algeria. Two ten-year-olds, Jon

Venables and Robert Thompson, were tried in an adult court in 1993 for murdering the toddler, Jamie Bulger. Both young boys came from extremely damaged and abusive birth families, resembling the dangerous 'gang families' previously mentioned (Meltzer, 1994, p.431; Bower, 2005, p.157). And both exhibited a desperate confusion of emotional neediness and brutalisation: "The violent child is the most potent image of violated innocence" (McEwen, cited in Alibhai-Brown, 2010). Victims of abuse sometimes move along a rather desperate trajectory. In attempting to get rid of their distress and anger over their legitimate dependency needs never having been adequately met, they seek to push this sense of helplessness and hopelessness into others, a projective defence that may develop into an abusive pattern of behaviour: "The hopelessness, the omnipotent control of the object and the disregard for its purposes, may be seen as defences against the dependence of primitive love" (Main, 1989, p.34). "Thousands of London's most profoundly disturbed children generate and live in a culture of 'normalised' violence...youngsters who are victims of child abuse at twelve are demonised when they become criminals" (Batmanghelidjh, cited in Cohen, 2013c, p.6). Forms of 'fighting back' deployed by young people include antisocial behaviour, violence, ganging up and scapegoating. As noted previously, aggression in a young child may be triggered by fear of the perceived loss of loved and needed parental figures. Both Kerie's and Dermot's mothers had emotionally distanced themselves from their young children. My experience of Kerie was that she was frequently in a state of mind where she felt a need to fight for and, if necessary, take by force what she wanted/needed because she despaired that it would ever be offered voluntarily. She often attempted to threaten, bully and coerce others, not only her peers but also parental adults including her social worker and the residential care staff. Her many statements that she wanted to kill herself seemed to be compounded of despair, dramatic attention seeking and threats. On one occasion she posed, knife in hand, at the doorway of a room in which a professionals' meeting about another young resident was taking place, screaming that she wanted to kill herself. This recurring threat was used to underline her expressed desire to be removed from Norfolk House. She also habitually spoke about 'punishing' professionals by running away, having a baby, or jumping off a bridge.

Batmanghelidjh (cited in Cohen, 2013c, p.8) recalls a former adolescent gang leader telling her, "I hate you because you have made me too soft to fight". In full fight mode, Dermot's understandable valency was to perceive almost all adults as opponents rather than as allies. Whenever he perceived parental adults as being deliberately withholding and unwilling to respond to his expectations - usually framed as demands for money or material goods such as a television or computer for his room at Norfolk House - he raged contemptuously against their meanness, sometimes threatening to take out a formal complaint, an action which he occasionally carried through. These attempts at manipulation and intimidation resulted both in the individual workers in his direct 'firing line' becoming increasingly wary of him; and also in the professional network splintering as different workers at different times felt more or less sympathetic towards his history and current situation (In chapter 5 I discuss professional defensive responses to the intensity of the young people's projections.)

Walker (2005, p.236) notes how troubled children and young people tend to be portrayed in media stereotypes as either "...little angelic victims or delinquent devils." One could argue that when the only roles apparently available are those of victim or of aggressor, to identify with the latter becomes an entirely understandable defensive strategy (Freud, 1966, p.109). Rustin (2001, p. 273) describes a young boy who adopted this defence:

Put simply, it was a clear case of identification with the aggressor. He felt that life had taught him two lessons. The first was, if you do not go on the attack, you are at risk of being the victim of an attack, and the second was, that if you get hurt, no one will care about what you are feeling.

Kerie came to Norfolk House with a history of stealing and lying which, in part, might be understood as an enactment of her failure to internalise a sense of appropriate boundaries between 'me and you', 'mine and yours'; as well as being an expression of her great neediness. Her habit, while placed at Norfolk House, of taking and hiding other residents' belongings felt to me like a perverted plea for the positive attention that her mother had withheld. Dermot's entry into care through a police protection order (PPO) was triggered by a physical fight with his mother after she had accused him of stealing from her. "Stealing is at the centre of the antisocial tendency, with the associated lying.

The child who steals an object is not looking for *the object stolen but seeks the mother over whom he or she has rights*" (Winnicott, 1990, p.125, italics in original). Kerie's lack of any clear differentiation between reality and fantasy, as manifested in her exaggerations, dramatisations and rationalisations reinforced her reputation for telling lies. It also helped to alienate her peers with whom she wanted to ally while at the same time anticipating, sometimes triggering, their rejection. The frequent rows in which she became embroiled tended to be usually initiated by her excitable efforts to 'join in', attempts which often involved bouts of competitive grandiosity, in the face of which other young people either withdrew or took up the challenge by taunting her. Kerie then fought back angrily, reinforcing her dual identity as both a bully and a victim of bullying. Rustin (2005, p.12) comments "It is often not at all simple to tell the difference between malicious dishonesty and the kind of confusion about truth which is part of borderline psychotic states". I often found myself wondering how aware Kerie was of the discrepancies between what she said and what was going on. To add to the confusion, it seemed almost as if she held a magical belief that if she wanted something enough, she could wish or coerce it into existence, be that a material object, a relationship or, ultimately, her mother's loving acceptance. (In chapters 5 and 6 I discuss similar manic defences, involving magical thinking, as I experienced them operating in Kerie's and Dermot's professional support networks.)

Delinquent acts may be carried out either by someone acting alone or as a member of a gang. Waddell (1998, p.128) writes about the prevalence of external and internal scapegoating and ganging up against another person or part of oneself that poses a threat to the maintenance of a particular, usually perverse, defensive structure. "The processes are particularly visible in adolescence in that pressures towards conformity on the one hand, and individuation on the other, are often at their most complex and most absolute." While claiming, through membership, to offer security, protection and freedom from anxiety, in reality the primary task of the gang, external or internal, is to terrorise and to inflict damage. "The main aim seems to be to prevent the weakening of the organisation and to control the members of the gang so they will not desert the destructive organisation" (Rosenfeld, 1971, p.249).

I have already referred to the sadomasochistic tendencies exhibited by both Kerie and Dermot, which could be understood as perverse aspects of their personalities 'ganging up' against more vulnerable parts. Both young people also occasionally attempted to join external gangs but these were insubstantial, very temporary arrangements. The occasional 'gang-like' alliances Kerie actually managed to forge with other young people at Norfolk House were characterised by the same rivalries and violent outbursts that had permeated her relationships with her own siblings. Wakelyn (2007, p.54), in her description of a young sibling group, comments, "It seemed that this gang state provided a kind of intimacy or togetherness, which may have offered some alternative to the desolation and disturbance that seemed to dominate their lives". Although Kerie desperately sought intimacy, she was unable to sustain it. Despite the intensity of her own endlessly thwarted desire to be at the centre of whichever group/gang she attached herself to, she was both temperamentally unsuited to and also excluded by others from the role of gang leader.

Dermot, like Kerie, was in general a loner, though again probably not by choice. He had been marginalised and bullied by his peers from early childhood, in part because parental neglect had resulted in his dirty, unkempt appearance and poor personal hygiene. (When I knew him he was, perhaps reactively, very fastidious and desirous to own fashionable and expensive clothes and shoes.) He gave me an overall impression that he felt under almost continuous attack, both from an adult world perceived by him as rejecting, hostile, patronising and/or infantilising; and also from his peers who engaged him in sexualised teasing which could escalate into bullying. He retaliated through biting sarcasm and insults - at which he was adept - or infrequently through physical violence. From time to time, however, he like Kerie gravitated towards highly ambivalent alliances with young people involved in delinquency. I understood such behaviour in Kerie and in Dermot both as an enactment of their frustrated desire for intimacy and also as an attempt to claim protection from the gang. Once, having told a staff member at Norfolk House that he felt unsafe with two other young residents who were bullying him in relation to his gender identity, Dermot joined in with these boys in a violent incident that resulted in him being escorted back to the home by police around 2 a.m. In general he had two strategies for making relationships, both with adults and with peers. These were either: to

'look after' them - possibly a displacement and inversion of his own dependency needs - or else to join in with their antisocial activities, in order to demonstrate that he was 'one of the gang'. His relationships with his mother, with his adult male friend and with his peers all demonstrated a mixture of these two approaches.

Kerie and Dermot both, with every justification, felt excluded from their birth families. For them, 'ganging up', even temporarily, seemed to offer somewhere to hide from their intra-psychic conflicts through the act of merging with others. Marginalised and alienated from mainstream society, a small minority of adolescents are tempted by the perverse invitation of the gang that seems to offer protection together with a sense of belonging and purpose. During a radio interview (*Today*, 2012) a former south London gang member spoke about the notion of safety as being central to an understanding of why young people join gangs<sup>5</sup>. He also referred to gang membership as giving a sense of belonging to a kind of family. It is, however, a perverse family organisation, inimical to differentiated thought or individual agency and as such reminiscent of the model of 'the gang family'. Instead of developing constructive and benign forms of cooperation, the gang sticks together. The sense of free-floating alienation and antipathy it exudes can all too easily be harnessed and exploited in the service of destructiveness: "The voice of the Godfather owes its main irresistible attractiveness to the ruthless, unthinking slogans of the gang that say that there is nothing sacred, nothing precious, nothing that is worth shedding tears" (Williams 1997b. p.62). Both dependency needs and legitimate parental authority are denied; and a perverse excitement is generated by challenging authority figures by acts of collective delinquency. In an ironic, rather poignant caricature of a parentless family, members call each other 'bro' or 'brother'. Gangs, traditionally male formations, increasingly attract young women who sometimes organise female only gangs. The girls that 'hang around' with male gangs are frequently exposed to the most blatant sexist stereotyping, which can spill over into overt sexual and physical abuse. There was considerable concern

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<sup>5</sup> **Contemporary youth gangs in London:** in 2013, the police identified approximately 250 gangs, with a membership of 3,500. Between 2007 and 2013 there were 124 teenage murders. Over the 12 months, April 2012-April 2013, 4,968 serious youth violence offences, including stabbings and shootings, took place [all statistics relate to London] (Cohen, 2013, p.5).

in the professional network that whenever Kerie went AWOL from Norfolk House, she was associating with a range of gang members, not just those in local gangs. Adolescents who are attracted to gangs are a small proportion of a much larger category of disaffected young people. They feel let down and disowned by, as well as painfully disappointed in, parental adults and a socio-economic environment that offers very little to those who are young, unskilled and unemployed. The official term is NEET – ‘Not in Education, Employment or Training’. In the first quarter of 2014, 975,000 people aged 16-24, i.e. 13.5% of people in this age group, were officially classified as NEET (Great Britain Parliament, House of Commons, 2014). The adult world, in response, may react punitively, an example of which is provided by a newspaper headline referring to the August 2011 riots, “Riots ‘caused by going soft on criminals’” (Higginson, 2012, p.1). Alternatively, an attempt could be made to recognise and address the tremendous difficulties facing multiply disadvantaged adolescents like Kerie and Dermot and their limited resources: practical, educational, social and emotional.

## **Summary**

Whether through neglect, violence or other forms of abuse, the early environment of most children who enter the care system has been malign. As a result they internalise a sense that the world is a hostile, treacherous and unforgiving place. Overwhelmed by feelings of anxiety, anger, fear, confusion and hopelessness, they engage in survival tactics. These include: being constantly on the move as a way of keeping unwelcome thoughts at bay; withdrawing into their own fantasy worlds; and/or fighting back through various forms of risk taking and delinquent behaviour.

## **Chapter 5. Tiptoeing up to or around the pain? The emotional impact of working with potentially overwhelming distress**

Such extreme vulnerability requires much sensitivity in the timing and wording of any approach and, for some children, one mistake may carry the threat of unbearable pain. As Donald Meltzer has said, sometimes one needs to 'tiptoe up to pain' (Hoxter, 1983, p.130).

### **Introduction**

In chapter 4 I focused on the first three of six overall themes identified in my case material: damaging early experiences; their devastating psychological impact on young people like Kerie and Dermot; and the different ways they will try to defend themselves. In this chapter I move on to explore my three remaining themes. Each theme in this second group links back to, and to some extent mirrors, one or other of the themes in the first group of three. My fourth theme discusses current features of the organisational and political environment in which social care and mental health workers practice. My fifth theme identifies ways in which the unwanted feelings of distressed and disturbed young people may become lodged in those who work with them. And finally, my sixth and last theme explores various psychological defences erected by workers in order to protect themselves against this painful emotional onslaught. While continuing to rely mainly on material from my two case studies to support my arguments, in this chapter I also introduce material derived from my two focus group interviews, with RCWs and with CAMHS clinicians.

### **Section 1. External worlds revisited: working in risk adverse, depleted, at time fractured and fractious professional networks**

...there is a complex system around each looked after child...(that) can make working together feel like walking through an emotional minefield. It is a system with a multitude of what I call 'fault lines' (Conway, 2009,p.23).

The young people whose life circumstances I describe in chapter 4 in my first theme, 'external worlds: childhood deprivation and abuse', have been brought up in damaging home environments which included early childhood experiences of parental ineffectiveness, inconsistency and neglect as well as, at times, overt abuse. In this chapter I introduce my fourth theme, 'external worlds revisited'. This theme, in turn, has four sub-themes: 'risk adversity', 'depletion', 'fractures' and 'fractiousness', each of which I discuss in turn. My argument is that the organisational environments, the 'external worlds', of social care and mental health professionals working with young people like Kerie and Dermot can also be deprived and even inadvertently abusive. The troublesome complexity, at times verging on chaos, of many contemporary professional networks, in combination with their provisional and temporary nature, inhibit their capacity to provide a work environment conducive to developing effective and collaborative working relationships. In their place, characteristics of ineffectiveness, inconsistency and neglect, in some ways mirroring the early life experiences of young service users, may at times surface in the relationships professionals have with their clients/patients and also with one another. In partial refutation of Lord Laming's (2003b, p.16) contention that the key to achieving an effective child protection service "...lies in doing relatively straightforward things well", Cooper (2005, p.4) argues that "A significant factor in explaining why competent people may not manage to do the straightforward thing is that the very unstraightforward nature of the daily task may, under certain circumstances, easily derail them from doing the blindingly obvious." In chapter 6 I explore the complexity of taking up a specific role and task, that of providing specialist mental health assessments for and within professional networks. Here I restrict myself to commenting on the importance of trying to tolerate complexity, rather than defensively attempting to over-simplify inherently messy and confusing situations and experiences.

### **1.1 Risk adversity**

Parsons and Horne (2009, p.44) note "...the growing tendency in our culture to assume omnipotently that risk can be eliminated, with a concomitant ethos of litigation when it cannot". Working in IAT, itself a multidisciplinary, dual agency

team, I was aware, not only of the complexity and challenging nature of the professional networks and other contemporary organisational frameworks that have become integral to contemporary social care and mental health practice but also how these networks are themselves embedded in even wider systems. As Campbell notes (2009, p. 8), “child protection agencies are nested amongst higher levels of society, such as the media and the government, that create meanings and expectations for the child protection work”. The political climate in which agencies charged with safeguarding and caring for children operate is predominantly one of risk adversity. This is partly engendered by a defensive desire to pass on the allocation of blame for failure and to ‘cover one’s back’. In her commentary on the media coverage of Jamie Bulger’s murder Toyne (2008) points out that, even though the number of children killed in England and Wales has actually decreased by 50% since the 1970s:

The banality of evil makes revenge unsatisfactory... That’s why the world needs to find more satisfying quarry to blame. Conveniently, social workers are always there to fill the role required by a frenzy of media hate. They failed to save a child, they are the true killers.

This ‘culture of blame’ (Conway, 2009), with the feeling engendered of needing to ‘cover one’s back’ at all times, can be discerned in comments made by RCWs, both about their own practice and that of others. One described a period in Norfolk House during which some team members were very apprehensive that the extreme behaviour of one young resident might precipitate a significant crisis “*None of us wanted that to happen while the child was here because of its repercussions for us as an organisation.*” Another RCW criticised the type of specialist report “*that is evasive in the sense that it recognises and acknowledges this...but it doesn’t want to do anything about it...It’s about slightly covering yourself but not willing to commit yourself to doing what you need to do*” (RCW focus group, April, 2013).

## **1.2 Depletion**

For some time the prevailing socio-economic, political and cultural environment in Britain has been one of uncertainty and cutbacks. More than twenty years ago Obholzer (1993, p.4) commented that uncertainty in many forms, including

over financial security and work was “the most powerful force at play.” Social welfare and health, especially mental health, budgets are continuously being frozen and trimmed back. Lack of resources is an understandable organisational preoccupation in the current political climate of ‘efficiency savings’ and ‘downsizing’. “Social workers and other frontline workers are placed in a painful and paradoxical position. In a climate of service delivery and packages of care, they look round for a resource and find that they are ‘it’” Bower (2003, p.150). An RCW participating in my focus group interview spoke about what she perceived as a failure to act on key recommendations in mental health assessment reports. In her opinion this was not *“as straightforward as disregarding. I think it seems to come down to resources... that it is based on finance as opposed to the actual resources that can best meet the child’s needs.”* Another RCW expressed her frustrated disappointment, *“To them, how I see it, it’s like to do with saving money. It’s all to do with cost instead of what we have recommended for the child, for the child’s best interests”* (RCW focus group, April 2013).

### **1.3 Fractures**

*“I think one of the major disadvantages, or one of the things that can cause problems for multidisciplinary work, is fragmented policy at government level which leads to fragmented service delivery on the ground”* (CAMHS focus group, January 2014).

It is hardly surprising in a wider environment characterised by resource shortages and fragmented policies, at both central and local government levels, that workers often assume defensive positions, distinguishing between ‘us’ (providers of frontline services) and ‘them’ (withholders of largely financial resources): “An awareness of limited resources coupled with clients’ projection of their own unbearable guilt creates an extraordinarily persecutory climate for social workers to work in” (Bower, 2003, p.149). Mutual suspicion, rivalry and friction between individuals, groups and categories of workers within professional support networks may become exacerbated. These traits, in turn, significantly impede the capacity of these networks to undertake what might be

called their 'primary task', that is to work collaboratively towards providing a consistently effective and compassionate support system for seriously troubled young people in the care system. Instead of holding onto what might be called 'work group' states of mind, those working within loosely constituted professional networks may instead individually and collectively switch over, at very short notice, to 'basic-assumption' states of mind, in which the predominant shared motivation is that of defence against overwhelming anxiety. Whenever this happens, networks become increasingly risk adverse, fractured and potentially fractious. Instead of collaborating, constituent agencies and professions withdraw into their own comfort zones or 'safe' positions, operating according to their different and possibly opposing organisational and professional values. Campbell (2009, p.6) offers one example of this tendency "...if the values of the police service encourage its child protection team to act quickly and decisively to remove a child from its family, the police may position deliberation and inactivity as not effective". A clinician commented in a similar vein *"I think about youth justice work. I think about, you know, sometimes there are disagreements from a CAMHS, dare I say it, clinical point of view We might have a very different view at times as regards how a case should be managed...."* (CAMHS focus group, January 2014).

#### **1.4 Fractiousness**

Horne (2001, p.15) comments on those times when "...warfare breaks out in the network or communication stops and unilateral decision making appears." It is understandable that tensions and mutual distrust generated by differences in perspective and organisational values and cultures among the many and varied professionals involved at any one time in providing care and support for looked after children occasionally erupt into overt hostility. When this happens abusive relationships and practices can emerge as part of the 'fallout'. Emanuel (2002, p.164) notes how "A social services department may...replicate these children's original experience of neglect, allowing them to fall through a hole in the 'net'-work." Kerie was inappropriately placed in a large comprehensive school, which she rarely attended, for several months before finally being suspended because education and children's services could not agree on what constituted an appropriate educational placement for her. Dermot's care plan was becalmed

for over two years because of a lack of professional consensus about where he should move on to after Norfolk House. I suspect that in both cases resource implications were also at issue although never overtly raised in professionals' meetings.

Emanuel (2002, pp.163-4) describes three types of deprivation experienced by looked after children. As well as being deprived by their life circumstances and by their ultimately crippling emotional defences (Williams, 1997a), they may also suffer deprivation as a result of the defences erected by workers to protect themselves from their young clients' intensely painful and disturbing projections (Britton, 1981). (I discuss some of these defences in section 3.) Parsons and Horne (2009, p.57) comment on the tendency of support networks to split, which can mean that different parts of the network are unable to 'hear' each other and important information is not communicated. One RCW felt that when a young person is not 'heard' by professionals, this is tantamount to abuse:

*They may be telling you stuff that they have suppressed and never said to any other professional before in the hope that they will be heard and something will be done and then the sad thing is that when they have done all of this, I've laid myself bare and then they don't get what they want. So, it's compounding or adding to whatever has happened to them in the past. It's like another form of, type of abuse in a way because then I have exposed myself and you have done nothing – so the whole lot of you, including my abuser and you all, you don't care about me (RCW focus group, April 2013).*

It can be grueling to work at the interface of child protection and mental health where uncertainly, anxiety - including that generated by child protection enquiries and serious case reviews - and the fear of failure is endemic. The difficulties are exacerbated by the amorphous work environment provided by professional networks, where personal and professional support structures such as teamwork, agreed and understood procedures and work priorities, clear lines of management, leadership and accountability and shared values are all in contention. Contemporary organisational forms at every level, from small work groups to large networks, are inherently unstable. This feature was noted by Sir Michael Wilshaw (2013, p.10) in the first Ofsted report on social care "The combination of unstable communities and political and managerial instability in our social care services is a dangerous mix."

## **Section 2. Internal worlds revisited: whose feelings are these anyway? The transmission of vulnerability, anxiety and a sense of deprivation**

Relationships between adolescents and adults are subject to three particular forces – anxiety, the projection of some emotional states under the pressure of managing intense feelings, and being 'swept along' by adolescent emotionality (Briggs, 2002, pp.84-85).

My fifth theme, 'internal worlds revisited: whose feelings are these anyway?' explores the feelings experienced by professionals in LAC support networks, many of which are projected into workers by deprived and troubled young people like Kerie and Dermot. Just as my fourth theme resonates with my first theme, so does this theme evoke my second theme, 'internal worlds: the devastating psychological impact of severely adverse formative experiences'. Within this fourth theme, I identify two sub-themes, which I call respectively: 'left holding the baby' and 'shell shocked'. The infant who lacks opportunities to temporarily project her/his feelings into a benign 'maternal object' who is able to hold onto them until the child is ready to re-introject them in a detoxified form, finds it terribly difficult to develop a capacity for internal containment of unwanted feelings. As a consequence, these may be evacuated and/or forcefully pushed, through words and actions, into other people, including professionals acting as substitute parental figures. Ruszczynski (2010) comments on the inverse correlation between a person's capacity to bear and process painful emotions, to recognise the existence of an 'internal world', and his or her need to export and lodge such feelings, intuitively experienced as intolerable, in other people. Because of the unconscious nature of their projections, they are inaccessible to reality testing and can grow to monstrous proportions. The ensuing toll on workers 'in the firing line' is heavy and their capacity to 'think under fire' is, therefore, severely compromised. Rustin (2005, P.12) notes the way in which, through the process of projective identification, the capacity of professionals to observe, question and think can be severely compromised. Instead of questioning a client or patient's belief system they may begin to mirror it. Through such distorted and distorting mirrors young people's defensive responses to unbearable emotional pain are re-enacted within their professional support networks at individual and supra-individual levels (c.f. Lord

Laming's (2003a) advice to social workers to adopt an attitude of healthy scepticism).

## **2.1 Left holding the baby**

*"We were glad, though we missed the child. We were glad when the child moved on because we no longer had that responsibility, serious stress and anxiety"* (RCW focus group, April 2013).

I use the expression 'left holding the baby' in order to capture the feeling of being left to carry a burdensome responsibility in isolation. This may, in turn, lead to increasing anxiety, disappointment, helplessness and resentment, together with a sense of being marginalised and deskilled. This bundle of painful feelings mirrors those experienced by young people like Kerie and Dermot, to which I refer in chapter 4 as 'spilling over' and 'not enough to go around', two sub-themes within my second main theme of 'internal worlds'.

Excluded from their families and tending to feel like so much discarded rubbish, young people in care may in turn deskill those in their professional support networks by evoking in them a hopeless sense that they themselves are no more than 'rubbish collectors' (Hoxter, 1983, p.128). Meltzer's (1992, p.38) concept of the 'toilet-breast' is similar in meaning, though applying more specifically to the analytic relationship. While it is essential that professionals are able to receive and process their clients' painful feelings, instead of making themselves defensively impervious to this emotional barrage, the accumulative emotional cost is extremely high and may over time give rise to acute and chronic resentment and/or near despair. Main (1989, p.12) refers to 'deep personal reasons' and 'abiding unconscious determinants' motivating workers in the caring professions. When nothing one does seems to bring about a change for the better, one's chosen identity as a helper may be fundamentally undermined. The worker, burdened with the task of 'holding the (unwanted) baby', may through projective identification experience feelings akin to those of a neglected or abandoned child that can in turn trigger a state akin to panic. "Just as an adolescent can feel helpless and terrified...so the staff who are

accompanying the adolescent on this tricky journey through adolescence can also feel helpless, terrified and disappointed” (Alfille-Cook, 2009, p.70).

In addition, young people who themselves have been chronically deprived are skilled in depriving those who work with them of many of the latter’s professional and personal attributes, including a sense of competence and confidence. When I was asked informally by the manager of Norfolk House if I would undertake a state of mind assessment report on Kerie even before she moved into the home, I understood this as an expression of the acute apprehension she was already generating in the staff team, concerning both their ability to work effectively with her and the potentially adverse impact on young people already placed in the home. A few weeks after her arrival, during a regular consultation meeting, I encouraged the team to think about their powerful counter-transference responses to Kerie. We explored how her enuresis and psoriasis might, at least partially, be understood as psychosomatic expressions of the intensity and desperation of her dependency needs by which they felt flooded. They described her as ‘sieve like’ in her constant need for attention and how they were finding themselves progressively depleted and exhausted by her inability to maintain any boundaries without continuous close monitoring. They also talked about beginning to feel an erosion of their own professional boundaries and capacity to keep her safe, a core task for the staff team and a mainspring of their sense of professional competence.

While offering regular consultations to the staff team at Norfolk House, there were times when I felt under considerable emotional pressure to support their position or point of view within the professional network, for example that a particular young person would be, or was, inappropriately placed in the home because of her/his significant emotional disturbance. My empathy with their sense of being unfairly ‘left to hold the (very difficult) baby’ made me want to ‘rescue’ them by recommending in my assessment report that the young person was not appropriately placed (c.f. Youell, 2002a, p. 203 on ‘rescue fantasies’). In parallel with this more or less benign feeling, I also had a rather different, more uncomfortable sense of being implicitly pressurised into ‘taking sides’, a defensive position which I discuss in section 3.

Alongside the residential staff team, Kerie's social worker was the other main receptacle for her unbearable feelings. Unfortunately splits in the support network, which were in part a consequence of the strength and direction of Kerie's projections, militated against the residential care team and the social worker thinking and working collaboratively, which might have helped to modify the toxic impact of her projections. Alfille-Cook (2009, p.70) refers to the way in which a troubled adolescent may go from one professional to another, looking for 'a magical solution' and how this process can engender competitive feelings between 'experts'. On one occasion the social worker contacted me at my other place of work in order to share, or perhaps offload, her feelings of helpless anxiety about Kerie's repeated threats to self-harm or even commit suicide unless her demands were complied with. I felt temporarily overwhelmed by a sense of unwanted responsibility for keeping Kerie safe, together with anxious uncertainty about what was expected of me. Rustin (2001, p. 276) describes the counter-transference feelings evoked when working with a young person caught up in a dangerous state of mind "I felt desperate as I began to recognize that at times he was in a murderous state of mind. It was very frightening to face the fact that he was psychologically capable of murder."

These apprehensions permeated the professional network, inhibiting their/our capacity to think and to assume agency. For example, at a particular network meeting convened in response to an incident involving Kerie in highly risk taking and sexualised behaviour, I felt all the professionals, myself included, were overcome by a paralysing sense of inadequacy in the face of the challenge to ensure her basic safety, let alone formulate a comprehensive care plan incorporating her therapeutic needs. When Dermot was initially placed at Norfolk House, care workers warmed to him as a 'lovable' and 'sociable' young boy towards whom they felt protective because other young residents, reacting to his flamboyant mannerisms, called him "gay". When however, he made a formal complaint about a staff member, the team became much more wary and critical, suspecting him of emotional manipulation. They increasingly felt cast collectively in the role, of the 'bad mother' while perceiving other professionals to be claiming kudos as his 'good mother' or rescuer. For example, the substance misuse worker who had been asked by his social worker to address with Dermot his heavy drinking and smoking, told me that the residential care

team felt Dermot was twisting him - the substance misuse worker - around his little finger, whereas he viewed his role as one of maintaining a positive and hopeful stance towards the boy. Such splits inhibited collaborative working relationships within the professional network, generating in both individual workers and various groupings, both professional and organisational, a sense of working in isolation, if not at 'loggerheads' towards each other. For the duration of my work with Dermot I remained unable to establish, let alone maintain, clear communication channels with his social worker. This was in part because the referral to IAT had been made by a social worker in the duty team who, even before my first session with Dermot, had transferred his case to a LAC team. Although I emailed his new social worker immediately with the date scheduled for my initial session with Dermot, stating that I would like to meet with her and to 'keep in close touch', she did not respond. I eventually managed to reach her by phone but I felt this delay had somehow 'got into the wood-work', stymieing all our subsequent contacts. Once I had completed my state of mind report, my formal involvement with Dermot came to an end. I continued, however, to 'run into him' occasionally at Norfolk House and heard about him at the regular staff consultations. I was also interested to learn about developments in his care plan, including whether any of my recommendations had been taken up. I emailed his social worker twice over two months but did not hear back. I eventually learned that she had left the department five weeks after the date of my second email. I still wonder if there was an element of shrugging off painful feelings of failure in her leaving the department without making any effort to inform me about the progress or otherwise of Dermot's care plan, which seemed to have become totally 'becalmed'. In her transfer summary, which I read some time later, she stated that children's services were still trying to identify a suitable foster placement for Dermot and that his present educational placement would come to an end the following month because of a withdrawal of funding. At that point no alternative educational placement had been identified although he was due to sit his GCSE examinations in four months time.

I felt that this communication breakdown exerted a significant and lasting negative impact on my visibility as a member of Dermot's support network. I remained unable to identify let alone work as part of a coherent professional

network around this young boy. Instead, it seemed as if various workers sequentially developed individual relationships with him, on the basis of which views were formulated that were frequently at variance with those of other, equally isolated, professionals. This turning away from coherent thought and action in the wider professional network left individual professionals to anxiously 'beaver away', each feeling isolated and overburdened. It is possible to draw parallels between the impact of Dermot and Kerie's painful early experiences of being ignored and excluded by their birth parents, their feelings of being misheard or unheard by substitute parental figures, and my own and other workers' experiences of marginalisation and isolation. On one occasion I remained unaware of a timetabling conflict with Dermot's Family Group Conference (FGC) until I arrived at Norfolk House in order to go through my state of mind report with him, something he had expressly said he wanted to do. No one had thought to inform me of the clash although I had copied his social worker and the manager and residential key worker at Norfolk House into my appointment letter. I felt irritated, resentful and in receipt of a mild narcissistic wound, from a perceived undermining of my role as 'expert helper'. Personal and professional preferences or vulnerabilities, grounded in both personality and history, influence not only career choices but also the adoption of particular roles and positions both towards clients and also professional colleagues and can, therefore, impact on feelings of self-worth. I am aware of a predisposition to locate myself at the margins of any social or organisational system rather than instinctively being a 'team player'. When my efforts to participate are subverted, I have, therefore, a tendency to feel slightly aggrieved! Through projective identification feelings can ricochet around the support networks. Kerie's social worker felt that educational colleagues did not take her views into account, while the residential care team frequently felt excluded from decision making processes, even though on a day to day basis they were the ones 'holding the baby'. According to one RCW, *"The discussion tends to happen in an external meeting forum, whereas it should be happening here in the environment that the child lives in... I think it's a failure to recognise the role that we have"*. Another RCW noted how such a feeling may pervade the professional support network *"The social worker wasn't listened to, the team manager wasn't listened to, the MALT person, the police weren't listened to, nobody"* (RCW focus group, April 2013).

## **2.2 Shell shocked**

“Panic is contagious: adults, even experienced workers, can catch panic from children...one has to hold onto one’s identity, to guard the frontiers of one’s self in a situation” (Dockar-Drysdale, 1993, p.126). I have called my second sub-theme ‘shell shocked’ in an attempt to convey a level of disturbance so intense that a worker’s capacity to think and respond clearly and effectively may be disabled and her ability to remain emotionally engaged in non-retaliatory ways severely compromised. Aspects of shell shock include: a sense of suspicion, confusion, alarm and threat that may at times tip over into panic or, alternatively, risk a paralysis of thoughts and feelings. When intense feelings are ricocheting back and forth between young people and workers, the sense of threat that the former can project makes it difficult for workers to think about the meaning of their behaviour. Being ‘under fire’ in this way renders the process of building and sustaining with a young person anything resembling a therapeutic alliance in the broadest sense extremely complex for frontline workers. While the adolescent’s distress will tend to evoke sympathy and compassion, his or her bitter resentment and rejection, together with the hostile defences s/he erects, may stir up less benign, possibly violent, emotions in a worker made to feel deskilled and worthless. These ordinary and understandable responses need to be contained and processed in order to minimise the risk of professional re-enactment when confronted by overwhelming emotionality. Hinshelwood (1998, p.20) refers to workers’ “...fear of something going quickly out of control... experienced as either madness or violence”. Projections can go in both directions:

...it becomes essential for the person working with children to become well aware of the possible violence within himself. We all know the gentle, patient person who arranges (unconsciously of course) for children to act out his violence while he stays calm and ‘good’ (Dockar-Drysdale, 1993, p.125).

Bullying behaviour, whether towards the young person or displaced onto professional colleagues, as well as a more general misuse of power and authority within professional networks, may have roots in violent, even momentarily murderous, feelings of retaliation. The sense of disturbance and threat engendered in workers may sometimes involve unconscious fear of contamination by a sexualised object. An example of the capacity to project

confusion together with intense apprehension was the extreme disquiet stirred up by Kerie - who had been sexually abused by both birth and step-father - in the residential staff team when she repeatedly called a particular senior male staff member 'daddy'. More generally, I sensed the RCWs, especially but not exclusively male staff, becoming increasingly distrustful of her motivation and fearful of the potential harm her allegations could inflict on their professional reputations. When, however, in reaction to her extremely needy, intrusive and at times sexually provocative behaviour, they tried to withdraw from interacting with her to protect themselves against potential allegations of sexual impropriety, she experienced this as rejection and redoubled her desperate, sexualised attention seeking efforts.

The RCWs, both individually and as a team, swung between two alternative ways of understanding Kerie's behaviour - she was either 'mad' or very 'bad'. If the latter, they felt less guilty about owning their negativity. In either case there was a sense that she was dangerous. They feared they might be held responsible for any harm she inflicted, and also that they could be physically hurt. I was aware of this conscientious, experienced and very professional staff team collectively wrestling with its instinctive wish that Kerie be 'moved on' as soon as possible. One of the clinicians spoke to this fear in articulating the need to address this anxiety when undertaking mental health assessments, "*It's about whether this child or young person might actually pose a risk to others as well as what the risk might be to him or her*" (CAMHS focus group, January 2014).

Kerie's emotional volatility resonated well beyond the residential care team. At times she stirred up in me and other members of the professional network transitory feelings of hopefulness by demonstrating apparent insight or self-worth. However, almost always such feelings were abruptly, almost cruelly, punctured by her words and, more often, her actions (c.f. case examples in chapter 4). I was unclear, and very possibly Kerie also, about whether she deliberately wanted to mislead or, alternatively, lacked any capacity to sustain hopeful feelings.

Within the professional network, her ability to influence different workers at any one time to take up polarised positions of hope or hopelessness rendered consistent and coherent thinking about her, based on the accumulative experience of the professional support network, difficult to sustain. An example of this was her statement to her social worker, passed onto me via an email, that she wanted therapeutic support but not from the one person in the network (that is me, in my capacity as the allocated CAMHS clinician) able to respond to this urgent request. I was left feeling, on behalf of her social worker and myself, the familiar mixture of hope, frustration and impotency. “Sometimes staff can be so afraid of doing the wrong thing that they do nothing at all” (Philpot, 2013, p.4). Another symptom of shell shock can be a paralysis of thinking, manifest through an inability to take any action. The state of being becalmed incorporates a sense of inertia, an absence of individual and collective agency and a pattern of history repeating itself:

Keanu died because people missed opportunity after opportunity to intervene...Professionals in the cases of Keanu Williams and Hamzah Khan met but failed to act...The response to all review and enquiries, stretching back decades, tends to be that ‘lessons have been learned’...Self-evidently lessons are often not learned (Philpot, 2013, p.4).

This sense of becoming becalmed might be considered as a transitional category between, on the one hand, a feeling state similar to depression, characterised by aimlessness, apathy and dejection and, on the other hand, a basic defensive technique, similar to freezing that originates from the impulse to take cover and/or turn away from emotional engagement with the caring task. (In section 3 I discuss defensive barriers to thinking and feeling, including ‘looking away’.) Rustin (2001, p. 281) reflects on her extreme difficulty in maintaining “...a level of interest and a sense of hopefulness” in her work with a young ‘looked after’ boy:

“...the intense loneliness I experienced was added to by the weak sense of life around [the boy, whose] social worker left soon after I started work. My phone calls and letters to social services fell into a bottomless pit of non-response... The sense of hopeless re-enactment which could not be resisted was colossal” (ibid.).

There was a delay of three months between the manager of Norfolk House informally suggesting that I undertake a state of mind assessment on Kerie and her social worker making a formal request to IAT. (The IAT protocol requires work to be jointly commissioned by the home and the allocated social worker.) It

then took another five weeks to agree a date for the three-way referral meeting and in the event there was no representative from Norfolk House. I wondered if the delays and 'empty chair' at the referral meeting might relate to the profound ambivalence, amounting almost to denial, on the part of her social worker about the appropriateness of Kerie's placement at Norfolk House. She consistently argued that Kerie needed a more specialist provision, a view which, although similar to that of the Norfolk House team members, also left them feeling that she did not believe they were 'up to the job'.

I experienced a similar lack of agency and inertia on the part of Dermot's first LAC social worker. In spite of continuing efforts on my part, I rarely met her and never on a one to one basis. Her lack of response to me mirrored her complaint about Dermot's mother's lack of response to her own attempts to make contact. Indirectly I learned that she was unsuccessful in identifying and then progressing an appropriate follow-up placement for Dermot. Although she felt he should move on quickly from Norfolk House, she did not think a foster care placement was appropriate and continued formally to favour rehabilitation without being able to engage his parents in an exploration of the feasibility of this option. I felt she was to some extent enacting Dermot's emotional elusiveness and quality of being a homeless orphan. (There really did seem nowhere for him to settle!) While I felt frustrated by her elusiveness, I also recognised that she, as Dermot's social worker, was at the sharp end of the inability of the professional support network - comprising social care, education, and CAMHS - to agree, let alone execute, an effective care plan for Dermot.

Thinking about how often social workers seem unable to take or act on decisions, Emanuel (2002, p.176) wonders if one reason might be a fear of becoming a hated 'bad' object, which "...may permeate all the way up and down the system...a powerful communication via projective identification into the professional of the child's experience of collapse in the face of contradictory states." The young person, the individual worker and the professional network all seem paralysed by unconscious catastrophic fears spiralling through the system. When hard to bear feelings cannot be confronted and processed, they tend to 'hang around' and be re-enacted. My case studies are studded with examples of processes grinding to a halt or replicating themselves, as if the

power of terribly painful emotions exercises a brake on agency, inhibiting the capacity to learn from experience (Bion, 1962a) and/or triggers processes analogous to the 'repetition compulsion'. Klein (1985, p.350) refers to "...the need in the child - and for that matter to some extent in the adult also - to repeat certain actions obsessively." Britton (1981, p.48), describing the ways through which professionals, without knowledge or intent, mirror and re-enact the early abusive experiences of the families and individuals with whom they work, notes that this process "...may eventually call attention to itself by its repetitious nature or by the impasses which seems to follow a variety of initiatives." He notes how what he calls 'complementary acting out' has the potential "...to infect the relationships of colleagues or different agencies" (1981, p.51). From her infancy, Kerie had been exposed to neglectful and abusive parenting and repeated physical, emotional and sexual abuse. In spite of the long-term involvement of social care and mental health services, little or nothing seemed to change until she was taken into care and even then she continued to experience multiple rejections as she was transferred from one 'failed' placement to the next. For example, an attempt to place her with long-term foster carers broke down within months. When her previous children's home had asked for urgent therapeutic help on her behalf to pre-empt her placement breakdown, the local CAMHS had given the home a 'dusty answer'. After one assessment appointment they declined the referral on the grounds that the support Kerie needed could best be provided by her residential placement, i.e. maintenance of the status quo.

It is almost impossible in such highly charged emotional environments to track where and with whom feelings originate. A sense of injustice, privation, frustration and mutual blame can all too easily pervade the professional networks caring for looked after children and adolescents. Unwanted and painful feelings are generated not only by the stark realities of the work environment and the unconscious emotional communications of the young people but also by the professionals' own resentment, guilt and fear of being publicly pilloried. These may be accompanied by feelings of inadequacy and a sense of abandonment faced with the momentous task of taking over from birth families, on behalf of society, the care of these children and young people. Inevitably there are times when the professionals 'fail' in the task. Referring to

his work in a psychiatric hospital, Main (1989, p.27) reflects “These failures did more than disappoint - they left all concerned with mixed feelings of uneasiness, personal blame, and defensive blaming of others. They got under the skin and hurt.” This description applies also to social care and mental health professionals working with young people in the care system. The result is an extremely volatile cocktail of painful feelings belonging both to the young people and also to those supporting them. When the distress of the children and adolescents becomes unbearable they do everything in their power to erect defensive barriers. It should come as no surprise that social care and other professionals also resort to the range of defensive strategies discussed below.

### **Section 3. When thinking becomes unbearable**

...defences against anxiety are not bad in themselves: social defences are necessary to the everyday fraught business of living. The question is, are the defensive behaviours that we observe in ourselves and others functional, or at times dysfunctional, not only in carrying out the work – the overt task – but in doing the essential undercover work of helping us to feel that we can achieve psychic survival in the business of living? (Dartington, 2010, p.27)

My sixth and final theme, ‘when thinking becomes unbearable’, like my fourth and fifth themes, has close links with a previous theme. The connection this time is with my third theme, ‘minds like minefields: survival tactics in a world shot to pieces’. Just as young people like Kerie and Dermot will ‘duck and dive’ to evade overwhelmingly painful feelings (c.f. chapter 4, section 3.), so too will the social care and mental health workers whose task it is to provide for their practical, social and emotional care. Through adopting and adapting grounded theory, I have identified five defensive manoeuvres frequently adopted at individual and/or collective levels by those working in professional networks. I have called these five sub-themes: ‘busyness’; ‘just get the procedures right’; ‘ways of looking away’; ‘passing the parcel/buck’; and finally, ‘taking sides and ganging up to scapegoat the outsider’. Bion (1967, p.47) draws our attention to how the capacity to make links between things and ideas, which logically and emotionally belong together, may be attacked when the outcome of such ‘joined up thinking’ is too stark a confrontation with painful reality. Although the

defensive splitting and fragmentation of thought and perception occurs initially at an intra-psychic level, ensuring that 'the right hand doesn't know what the left hand is doing', there are psychosocial ripple effects. Within professional support networks, relationships between individual workers and between different parts of the network will be adversely affected.

Everyone needs defences, especially in work that involves continuous risk assessments. "When defences are stripped away, the work can feel meaningless: at best flat; at worst unbearable" (Zagier Roberts, 1998, p.47). However, recognising the tipping point at which functional coping responses, including creating a 'thinking space' and sustaining a sense of hopefulness and competence, may become avoidance tactics or manic omnipotence can be anything but straightforward. Defensive manoeuvres can disable, rather than enable, the capacity to think by, for example, replacing mindfulness with mindless activity or evading the need for independent thought through following 'rules' in a rote way. Both these strategies bear strong family resemblances to those adopted by the young people in my study. "Whether we be therapists or substitute parents, we are liable to find in ourselves defences which are not dissimilar to those of deprived children" (Hoxter, 1983, p.126). Different workers, or the same worker at different times, may assume a variety of defensive strategies, including immersion in the manic task of 'rescuing' a young person and withdrawal from emotional contact to a stance of professional reserve.

When I first began to work with the residential care team at Norfolk House, while genuinely dedicated to caring for the young people placed in the home, they had developed a staff culture that enabled them to maintain a certain emotional distance from the young residents. They felt comfortable operating as a short-term (maximum three months) placement for adolescents mainly around the age of fifteen, most of whom soon moved on into young people's hostels. When Kerie was placed at Norfolk House eighteen months later, the home had only just officially changed its remit, at the insistence of the local authority who block contracted all its beds, from a short-term assessment service to a medium-term adolescent children's home with the much younger minimum age, of twelve - Kerie's age. The RCWs were openly apprehensive and on the whole

reluctant about both changes, citing as one of their main reasons that they felt much more comfortable working on a short-term basis with an older age group who were preparing to move into semi-independent accommodation. One care worker openly voiced her apprehension that she would become too attached to younger adolescents who stayed for a longer time. Hinshelwood and Skogstad (2000c, p.156) argue that there are two pseudo reasonable assumptions underlying defensive techniques: firstly, if one remains emotionally distant from patients one won't feel anxiety oneself; and secondly, if the responsibility for decisions is passed to someone else, any residual guilt will also be handed over. At least four of the five popular defences I examine relate to one or other of these assumptions.

### **3.1 Busyness**

“The defence of activity, commonplace in adolescence, becomes too easily enacted in the network around the delinquent and in the public domain” (Horne, 2004, p.330). Punctiliously ‘going through the motions’ (Foster, 2002, p.95) may afford respite from the need to accept personal and professional responsibility in situations of intrinsic complexity. A residential care worker spoke of her frustration when the network goes into this mode of behaviour, “...*we attend meetings, we go to meetings, the report gets read out, we read the report, we go through the report and that seems to be, that's it*” (RCW focus group, April 2013). I find it alarmingly easy to feel, and even to convince others, that I am immensely busy – after all, in contemporary, risk adverse agencies ‘desk work’ alone is potentially limitless. The professional defence of busyness has much in common with that of ‘keeping on the move’ (c.f. chapter 4, section 3) a tactic adopted by some young people, including Kerie and Dermot, in order to distract themselves from unbearable emotional pain. Wanting, perhaps needing, to offer support and help but also at risk of feeling overwhelmed by the emotional rawness of working with severely distressed young people, practitioners may deny the extent to which the young people ‘get under their skin’ and instead become very busy providing practical help. Business, busyness and anxiety have shared etymological roots. As this flight into activity is a characteristically adolescent defence, it should come as no surprise when those drawn to

working with young people take a similar stance.

During the period I was meeting with Kerie in order to prepare my assessment report, there was a spate of professional meetings. In addition to her regular LAC reviews, these included several ad hoc professional network meetings called in response to contemporary incidents of sexualised behaviour with peers and also her disclosure of historic sexual abuse from a care worker in a previous placement. Even though, or perhaps because, the anxiety level at these meetings was extremely high, they felt rather inconsequential. Kerie continued to be extremely vulnerable and to behave in sexually provocative ways and a sense of inertia, almost of paralysis, seemed to overtake the professional network. On both occasions her social worker convened care planning meetings, key educational professionals either did not attend or rehearsed their long held opposition to her social worker's view, which I supported, that Kerie should be transferred to an integrated residential, educational and therapeutic placement. This impasse prevented any consensus about how to move forward and the network remained effectively disabled in spite of apparent activity.

In order to allay their fears about being inadequate to the task of helping their young clients, workers are tempted to take the attitude that 'something' must be done' and to precipitate themselves into action as an alternative to slowing down sufficiently to be able to reflect on the appalling experiences of these young people. This impulse, which is not dissimilar to the types of 'second skin' defences of restlessness and hyper-activity observed by Bick (1964; 1986) in disturbed children and young people (c.f. my observations of Kerie and Dermot in the previous chapter), has the aim of ensuring "...that every second is filled and no spaces are available for thinking" (Emanuel, 2002, p.167). Such manic activity is tantamount to 'whistling in the dark' in order to keep at bay fear of failure. An omnipotent attitude may be summoned up to counteract an underlying fear of impotence and the worker is tempted to entertain magical solutions or 'cures'. The roles of 'rescuer' and 'activist', which may be more or less imposed on a worker by professional colleagues who feel at a total loss as to what to do, might have secondary gains for the worker recruited into such a role. On one occasion, after a protracted period during which Kerie's social

worker had made no contact, she rang me 'out of the blue' to ask if I would see Kerie urgently. She was about to take annual leave, a circumstance that had perhaps triggered panicky feelings in relation to her young client's repeated threats to self-harm. In spite of my serious reservations about the effectiveness of this course of action, I found my self reluctantly acceding to her request. On reflection, I think I felt flattered to be 'needed' and that my response was probably motivated more by my wish to be identified as a useful member of - rather than as marginal to - the professional care network, than because I thought such a meeting would be productive. In full 'action mode' I also requested a psychiatric interview for the following week, even though the psychiatrist and I agreed that this would be more to reassure the professional network that everything possible was being done rather than as being of any likely diagnostic benefit.

Such bursts of anxious activity had a tendency to erupt after fairly long periods of quiescence in the professional network. Even when active, it was sometimes difficult to differentiate between a genuine sense of agency and a manic need to act in order to avoid feelings of hopeless frustration. After completing Kerie's state of mind assessment report and presenting my recommendations, I felt as if I had been informally 'uncoupled' from her professional network. I received no information about the outcomes of previously heated communications between different agencies in relation to her care plan, other than hearing second hand that she had moved placement. I was seriously questioning whether there was still a role for me/IAT when the access to resources team (ART) social worker sent an urgent email to me, as well as to Kerie's social worker, the latter's line manager and the IRO. This email detailed Kerie's continuing aggression, sexualised behaviour, absconding, and school refusal, and emphasised the extremity of her underlying disturbance. It also noted that she had recently asked for therapy. I was surprised that an ART social worker, rather than Kerie's allocated fieldwork social worker, was making an attempt to galvanise the network. It is possible that she was motivated by what Bower (2003, p.149) refers to as "...persecutory guilt generated because they feel unable to 'do' anything to attenuate the painful experiences of their young clients." This email prompted Kerie's social worker to contact ten members of the professional network (in my experience networks tend to expand in ways that are not

purposeful) including myself stressing the need 'to act quickly' but without specifying who should do what, other than that Kerie should be provided with therapy. Perhaps her response was triggered not only by the ART social worker's initiative but also by pressure from staff in Kerie's current residential placement, whose turn it now was to 'hold the out of control baby'. In any case, the social worker's identification of individual psychotherapy as what Kerie needed was a rather magical solution. I had stated in my assessment report that I did not consider Kerie would be able to make effective use of individual psychotherapy at this time. This scenario is similar to one depicted by Horne (2004, p.332) in which the professional network 'went into a deep silence' after referring a young boy for individual therapy and receiving in response an assessment recommendation for a residential placement on the grounds that "...only once he experienced containment could any therapy be offered." Three months later he was re-referred for individual therapy. The same response was given, after which the network went into a second period of silence, only broken when his current living situation had completely broken down. He was finally provided with and settled into an appropriate residential placement, as had originally been recommended. Similarly with Kerie, it was not until both her subsequent placements after Norfolk House had broken down, that an integrated therapeutic and educational residential placement, where she remained for the following four years, was identified for her.

The worker's need to be helpful may lead to her client being implicitly coerced into accepting ultimately unhelpful 'solutions' as a defensive way of managing the worker's own fear of helplessness and condemnation - by the client, by colleagues and ultimately by the worker him/herself - for being a failure. A practitioner infected by this fear may become desperate for a young person to respond positively and actively to overtures of help. Winnicott (1990, p.155) describes how the adolescent capacity to be in 'the doldrums' threatens that part of ourselves "...that has not really had its adolescence" and can drive the parent or substitute parent to want to find solutions, most of which will be false. Even though I had major reservations about what was being asked and/or expected of me, of CAHMS and of psychotherapy, I agreed to visit Kerie the following week at the small residential home to which she had recently been transferred. After initially refusing to see me, she changed her mind and talked

with me briefly in a friendly and coherent, if rather superficial and manic, way. Having offered me an idealised picture of her life in the home, completely at variance with reality, she abruptly rolled up her sleeve to reveal deliberately inflicted cuts on her arm and then turned angrily away from me towards her residential key worker. I felt the poignancy of this act because I understood Kerie's response to me to be, at least in part, a justifiable complaint that I was just another professional 'passing through' her life. I was also aware, as almost certainly Kerie was not, that this young woman, who she seemed to like, was an agency worker who would be leaving at the end of the week. Soon after my meeting with Kerie, I learned indirectly that she had been moved to yet another adolescent home, this time away from London. I subsequently emailed her social worker five times requesting an update about her situation and asking if, in her view, there was still a role for me because, if not, I would need to close the case to IAT. I eventually heard back from the social worker but only to give me the name of Kerie's new residential placement. As I was not requested to undertake any further work I then formally 'closed' the case to IAT.

With Dermot also, I became anxious to convince my colleagues and myself that I was both integral to, and a productive member of, the professional support network. Although my usual practice was to meet with a young person three times as part of an assessment, I found myself offering Dermot five sessions. On reflection I think I was rather seduced by his apparent eagerness to meet with me, which bolstered my sense of being useful. I came to realise, however, that by being so unboundaried in my practice I had probably fostered in him an expectation that we would continue to meet, which I then disappointed. My own need to feel appreciated had inadvertently confirmed his suspicion that parental adults were not to be trusted to 'stay around' and in this way contributed to his rejection of further counselling or psychotherapy. It is possible that a similar dynamic was being played out between Dermot and his substance misuse worker who continued to meet fairly frequently with Dermot well beyond that service's short-term remit.

In addition to the manic 'busyness' demonstrated by individual workers and by professional networks 'in full swing', various employment practices associated with the contemporary emphasis on 'flexible labour markets' provide ways of

keeping the emotional impact of the work 'at arms length'. These include high staff turnover, agency working and short-term contracts, all of which are evident in social care. Kerie retained the same social worker during the year I worked with her, a year which however covered three placement moves, two precipitated by placement breakdowns. Dermot was less fortunate, having three social workers in nine months before being transferred to a social worker in the 'leaving care' team soon after his sixteenth birthday. Whether high turnover derives from individual decisions - for example one of Dermot's social workers resigned - or from the way an organisation is structured - Dermot was transferred from a 'duty and assessment' team to a LAC team to the 'leaving care' team during this period - it is imposed on service users by professionals and is highly disruptive to relationship based practice. It is also endemic at every level in social care, for example one in three local authorities changed their director of children's services over the twelve months prior to October 2013 (Davis, 2013).

### **3.2 Just get the procedures right!**

Munro (2011, p.6) refers to "...a commonly held belief that the complexity and associated uncertainty of child protection work can be eradicated." Sticking to procedures, 'going by the book', is similar to defensive busyness in that it serves to shield against emotional engagement. "Human kind cannot bear too much reality" (T.S. Elliot, 1945). It is hardly surprising, therefore, that workers are tempted to hold onto either self and/or bureaucratically imposed caveats to follow procedures, as a way of blocking out the emotional distress inherent in confronting the bleak reality of their clients' external and internal worlds. Under the onslaught of a heavy workload, social care workers may 'take cover' by withdrawing from 'the front line' and instead bury themselves under the ubiquitous piles of paperwork, or the electronic equivalent which, perhaps rather conveniently, keeps them tied to their desks and the relative safety of the bunker that the office can become. These military metaphors, evocative of flying bullets, capture the somewhat persecutory quality pervading highly stressful work, which sabotages the primary task of supporting distressed and disturbed young people. While a focus on bureaucracy and compliance can help to bind

the free-flowing anxiety that permeates professional networks operating in a risk adverse organisational climate, the underlying assumption that "...we just have to get the procedures right and the enterprise will work efficiently" (Dartington, 2010, p.14) is fallacious. Menzies (1960) in her discussion of 'social defences' includes that of ritualised task performance. The wishful thought is "if I 'go by the book', 'they' – whoever they may be – won't be able to isolate and scapegoat me." Related ways of reducing the emotional burden of individual responsibility in a risky and therefore anxiety provoking work environment include: the adoption of targets, performance indicators, checklists and other forms of standardisation and regulation. While having the potential to enhance practice, they may also be used defensively to erect protective but ultimately dysfunctional boundaries between worker and client.

It is possible to introduce a comfortable and comforting but spurious order into the work. Although it became apparent soon after she arrived at Norfolk House that Kerie would benefit from a smaller, more specialist placement, it took two further placement moves and many months before this was achieved. The rationale given for this delay by children's services was a policy requirement to bring her back to London where she was born and to place her near her family, even though she did not see her mother once, to my knowledge, during her placement at Norfolk House. While it is appropriate to make determined efforts to maintain links with family and place of origin, Kerie had lived away from London for several years and there was no plan for her infrequent contact visits to increase, let alone for her to return permanently to her family. I wondered to what extent the formal position taken by children's services might serve to rationalise an underlying failure of professional agency. Rustin (2005, p.18) discusses how procedures may over-simplify messy situations which do not 'fit under a tidy label'. Another example of rigid adherence to a policy was the requirement for a young person to move on from Norfolk House when s/he reached sixteen. After a failed attempt to identify a foster care placement, Dermot was told that he would be transferred to 'semi-independent' accommodation, i.e. a hostel. As well as providing a false clarity - described by Obholzer (2000, p. ix) as 'the clarity of blindness' - this policy, based on the unrealistic premise that a young person is 'semi-independent' at sixteen, is a manic defence against the need to acknowledge the extent of young people's

ongoing dependency needs. Dartington (2010, p.50) criticises "...policies that are fatally disrespectful of dependency." I suggest that this is one such example.

While they may help to avoid individual and systemic inertia, tight time frames and other boundaries around the work contract can also be used defensively as a way of avoiding emotional engagement with clients. Kerie was placed at Norfolk House soon after the home had officially changed its function from a short-term adolescent assessment service to a medium-term adolescent children's home. In addition, the age range had very recently been extended downwards in age, to include those as young as thirteen - indeed Kerie was not quite thirteen when placed there. As discussed above, the residential care workers were openly apprehensive and, on the whole, reluctant about both changes, citing among their reasons that they felt more comfortable working with an older age group who were preparing to move into semi-independent accommodation. One voiced her fear that she might become too attached to younger adolescents who stayed for a longer time. In my own service, although all the IAT clinicians other than trainees were permanent staff, we were contracted to undertake specialist assessments of children, young people and families which were, in theory at least, clearly demarcated and short-term. This practice facilitated the maintenance of professional distance between clinicians and clients.

While policies, procedures, 'good practice guidelines' etcetera may sometimes be used to oversimplify a messy reality, they may also become increasingly elaborate and full of empty detail. Meltzer (1992, p.120) refers to those times when "...conscious confabulation replaces unconscious thought." It may be simply too harrowing, when contemplating the emotional damage suffered by some young people, to engage in 'joined up' thinking which is, therefore, replaced by empty detail. Court reports submitted by social care and mental health professionals are frequently criticised for being long on description and short on analysis. Horne (2009, p.113) reflects on the temptation, when writing about young people who generate anxiety and confusion in professionals, to look for "...reasons and possibly a sense of containment and control in the exactness and logistics of things because the emotions are unbearable. Or one

seeks, in the detail, an avoidance of the whole.” When I was writing up my state of mind assessment reports, I became increasingly conscious of adopting the practice of writing ‘all you know about x’ rather than ‘answering the question’.

### **3.3 Ways of looking away**

“The final irony was that Haringey Social Services formally closed Victoria’s case on the very day she died” (Laming, 2003b, p.3). It is perfectly possible for conscientious workers to engage in various ways of ‘looking away’, keeping their clients ‘out of sight and out of mind’. Their unconscious fear is that recognition of the extent of their clients’ difficulties would undermine their sense of professional competence. The temptation is to withdraw, detaching oneself emotionally if not practically, from anything other than superficial contact with the young person’s reality.

#### **The rule of optimism**

Maintaining the ‘rule of optimism’ is one of several unconscious strategies available to workers who want to minimise or repress both intra-psychic and interpersonal anxiety and conflict. In this defensive manoeuvre, which is associated with the omnipotence that also fuels manic activity, the worker focuses exclusively on manageable, preferably positive aspects of the work, rather than fully recognising a complex, ambivalent and bleak reality. One RCW, in response to a focus group question about identifying helpful characteristics in a specialist mental health assessment report, responded “*Assessments have to be about solutions because they [the young people] have already experienced everything so let’s look at solutions.*” While understandable, this is not always realistic as there may be no clear ‘solutions’. In a different context the majority of RCWs at Norfolk House, who became increasingly critical and wary of Dermot, indirectly accused his substance misuse worker of defensively maintaining the rule of optimism. This worker, while acknowledging that his approach was not to question or appear to doubt whatever Dermot chose to share with him, perceived himself as pursuing a deliberate tactic aimed at establishing a positive working alliance - in psychoanalytic terms a ‘positive transference’. It could be argued that his valency was for the role of ‘pal’. It is an

open question whether or not he was 'whistling in the dark'; adopting a collusive, 'rose tinted' view of Dermot's potential for emotional growth that denied the deep psychological damage that had been inflicted on him. A worker who assumes a blindly optimistic approach is almost inevitably frustrated by the intensity with which the young person's unfulfilled dependency needs resurface. When this happens, the worker may turn away with covert bitterness from their disappointing client and seek protective cover. Such a withdrawal may be long-term or else part of a volatile and repetitive cycle of close involvement and disappointed withdrawal, mirroring the typically adolescent claustrophobic-agoraphobic dilemma described by Rey (1979). When combined with swings between idealisation of the young person's energy and creativity and denigration of their self-sabotaging behaviour, the volatile and sentimentalised climate created between worker and young person may wreck the professional helping relationship. "Depressive anxiety leads us to find different ways of splitting off part of our experience, often colluding with our clients by focussing on the good aspects of the relationship while overlooking their destructiveness" (Foster, 200, p.92). Even though the worker would like to shut out awareness of negative feelings engendered by the young person's failure to respond to overtures of help, their continuous re-emergence triggers escalating anxiety, guilt and compulsively reparative wishes. This vicious cycle reinforces the worker's desire to maintain an emotional distance from young people like Kerie and Dermot. It is perhaps not coincidental that the substance misuse worker, having embarked on a theoretically short-term, focussed piece of work with Dermot, remained involved for several months on a 'drop-in' basis. Having said that he would share with me his assessment report, this did not happen and his work with Dermot seemed to peter out in an atmosphere of mutual disappointment.

#### *Turning a blind eye and a deaf ear*

If one can persuade oneself and/or another that nothing much is wrong, then nothing much needs attention. Lord Laming (2003b, p.6) recounts in his summary report of the Victoria Climbié Inquiry, how a local councillor had told him that if she asked any questions of the director of social services, the latter would reply "...everything is okay, do not worry, if there is a problem I will let you know." Although Kerie had not attended school for some time before her

placement at Norfolk House, and in spite of her disturbed history, the local authority decided that she would attend a local mainstream comprehensive school, a clear example of education ‘turning a blind eye’ to the reality of her situation. When I visited Norfolk House soon after Kerie’s arrival, I learned that her extreme behaviour was severely testing boundaries at school as in the home. She frequently refused to attend and when she did so she revealed an almost total lack of peer group social skills as well as flouting adult authority. This led, before long, to her suspension. Even so, the educational authority continued to insist that she did not need a specialist educational placement and the residential care staff were left to ‘hold the baby’ while social care and education argued the point. The disjuncture between what was known about Kerie’s emotional disturbance and neediness, together with her inability to contain her anxieties, and the plan for her to attend a local comprehensive school, amounted almost to a type of dissociation on the part of education. In a defensive reaction to intolerable levels of helpless anxiety that threatened to leave them feeling deskilled, residential care workers also began to adopt this form of defence. Struggling to understand and contain her needy, volatile and out of control behaviour, some began to minimise or positively reframe the extent and meaning of her distress and disturbance. A female residential care worker articulated this attitude during a regular staff team consultation “*She is a nice little girl who just needs really looking after and caring for.*”

Dermot was an articulate young person who tried to hide his dependency needs by relating to professionals in defiant and instrumental ways, using his ‘sharp tongue’ to secure material needs. Workers tended, in consequence, to perceive him as a resilient and resourceful boy and to ‘turn a blind eye’ to the extent of his emotional deprivation, which meant that his significant vulnerability was largely overlooked. The intensity of a young person’s wish and need to be perceived in particular ways, in Dermot’s case as independent and ‘street wise’, implicitly invites workers to bury their heads in the sand, entering a collusive and paralysing state of unreality. There may also be an element of placation in workers’ responses, a desire not to ‘rock the boat’ by challenging, no matter how sensitively, the young person’s denial of their own pain for fear of triggering an eruption of uncontrolled anger:

The question which must be borne in mind when we remove our attention from the suffering of the child is do we do this in the service of helping the child or in the service of protecting ourselves from our own suffering? (Cooper, 2005, p.6).

While writing and disseminating Kerie's state of mind assessment report, I became increasingly aware of her capacity to create fractures within the professional network. One of the most significant disagreements was between her social worker, who had become consumed with helpless anxiety, and residential staff at Norfolk House, who – having for several months been the main voice within the professional network conveying the extent of Kerie's disturbance – had become increasingly desensitised and 'laissez faire'. So, for example, a prolonged and physically violent altercation with another girl was described by a care worker as 'a little spat', while her overall behaviour and its possible consequences was judged as being, in the words of another RCW "...in the lap of the gods...", rather than amenable to adult boundary setting. Although an understandable group defence against the daily onslaught of her extreme volatility, this attitude placed a very experienced, though emotionally depleted, team at risk of 'turning a blind eye/deaf ear' to the degree of risk to which Kerie exposed herself through her impulsive and dangerous behaviour. After one of her extended outbursts she told the deputy manager, "*When I feel that bad I want to kill myself.*" It is hard to overestimate how extraordinarily difficult and painful it must have been for the team charged with her daily care and protection to be repeatedly exposed to high anxiety. Not surprisingly when I tried to communicate my view that, while her outbursts were largely attempts to gain attention and some degree of control, there was a very real risk that this could result in her taking serious, if not fatal actions, I felt strong emotional resistance. This was not what either the social worker or the residential staff team wanted or could bear to hear as it did nothing to allay the anxiety of the former and could be perceived as placing an even greater burden of responsibility on the latter. It was totally predictable that those in the professional network responsible for Kerie's care were tempted to turn away from the extent of her disturbance and vulnerability, exposure to which left everyone feeling deskilled.

In the Oedipus story "...not only did all the chief characters turn a blind eye but an unconscious or half-conscious collusion took place, since if any one of them had exercised their curiosity the truth would easily have come out" (Steiner 1993, p.121). While the rule of optimism is an exhortation to focus exclusively and rather manically on what one hopes to see, the related defensive technique of turning a blind eye or deaf ear involves a refusal to see or hear anything that may be troubling or require remedial action. Both defences rely on a radical disconnection between what is observed and how this is understood. Such a repudiation of the painful reality of what is before us, amounting at times almost to dissociation, is "...a very ordinary defence when we are deeply conflicted about what we are seeing, or about what we have come to know" (Cooper, 2005, p.8).

#### *Going absent without leave (AWOL)*

I use this term to describe an extreme variant of 'looking away', which involves absenting oneself entirely in an emotional sense for a shorter or longer period. While having something in common with inertia and the state of being becalmed, it involves a more deliberate withdrawal of individual and/or collective agency originating from a protective impulse to take cover from the emotional impact of an enormously difficult safeguarding and caring task. In his inquiry into the death of Victoria Climbié, Lord Laming (2003b, p.6) comments on the "... reluctance among senior officers to accept there was anything they could have done for Victoria." Just as, when stressed and under pressure, people may opt physically to go AWOL, so they may defensively absent themselves from feeling and thinking. Kerie and Dermot both habitually absconded from Norfolk House for hours or days at a time and engaged in various techniques to achieve mindlessness, including extreme risk taking activities. Workers in their support networks also sometimes went AWOL both literally, for example by not responding to emails, telephone calls, etcetera and by absenting themselves from network meetings, as well as by failing to keep things in mind and to make connections (Rustin, 2005). I noticed when Dermot was initially placed at Norfolk House his absconding and risk taking activities generated significant anxiety and that he stirred up strong feelings, both positive and negative, within the staff team. After a few months, however, his name was rarely mentioned in staff consultations. It was as though he and his behaviour had been somehow

assimilated as being 'just the way it is' and he was no longer securely 'held in mind' by the residential staff team, by his social worker or by the education service. As professionals increasingly withdrew their attention, going mentally AWOL, Dermot became more strident and demanding, which I suspect is a self-protective dynamic he had learned very young in relation to his birth parents.

Defensively adopting ways of emotionally and mentally absconding contributes to the sieve like quality sometimes apparent in professional networks. "This absence of thoughtfulness is just as much in evidence at the level of systems" (Rustin, 2005, p.19). There may be defensive and collusive silences within networks combined with a systemic unwillingness to acknowledge that 'the emperor has no clothes on', or to recognise 'the elephant in the room'. Information deficits, for example about historic abuse or the reasons for previous placement breakdowns, remain unplugged with the result that care planning is severely compromised and history may very well repeat itself. On one occasion, in an attempt to bring the professional network together to think in a more holistic way about Kerie's needs, her social worker arranged a network-planning meeting that I attended. However, the discussion was stymied by the absence of educational representatives who subsequently challenged a key decision of the meeting, i.e. that Kerie should move to an integrated educational and therapeutic placement. (I had also recommended this course of action in my earlier assessment report.) Kerie's ability to project different aspects of her volatile personality into different workers, resulting in the professional network as a whole being unable to think coherently about her and to make a consistent assessment of the extent of her difficulties and needs, has already been noted. This may help to explain how the education service was able for such a long time to maintain that Kerie could be educated in a mainstream placement even though her attendance was very poor, her behaviour extremely disruptive, her academic performance alarmingly low and with the head teacher threatening to suspend her indefinitely.

A similar turning away from 'joined up thinking' also at times infected Dermot's professional network, resulting in individual professionals working in silos rather than collaboratively. I have previously mentioned the time I arrived at Norfolk House for a pre-arranged session to find another appointment had been booked

for Dermot at the same time. On another occasion I phoned Dermot's social worker to check whether his next LAC review, scheduled for the following week, would be going ahead. I was concerned on two counts: I had received no confirmation and, more importantly, I was aware he would be unable to participate on that date as he would be taking part in the home's annual seaside summer holiday. Neither the social worker nor his residential key worker had noticed the clash of dates and while the social worker subsequently amended the review date, she did not inform me of the revised date and time. Fortunately, Dermot's residential key worker thought to do so.

### **3.4 Passing the parcel and passing the buck**

Whereas in the previous cluster of defences workers find various ways to turn away from their clients' difficult emotional communications, in the defence I call 'passing the parcel' workers who are subliminally aware of their clients' high levels of distress and disturbance and feel threatened by feelings of professional inadequacy, seek ways to shift the responsibility onto others. The emotional burden of guilt generated by feelings of inadequacy and failure can be passed endlessly around the professional network in a perverse version of the party game. In drawing attention to this 'buck-passing phenomenon', Main (1989, p.20) gives an example of this defensive practice, which is fuelled by anxiety and guilt over failure:

Our referring doctors were the most recent link in this chain of helpers. They too had failed to rescue the patient, were uneasy at their failure, and were inclined to blame others, especially relatives, but sometimes colleagues.

Professionals, like everyone else when feeling uncertain, uneasy and under pressure, may adopt the tactic of 'attack as the best form of defence' in response to the covert criticisms perceived to be contained in different perspectives or positions. Anger, blame and mutual contempt can reverberate, through processes of projection and projective identification, among workers, who "...may idealize themselves while blaming managers, or an agency may idealize its own work while denigrating the work of other agencies with their clients" (Foster and Zagier Roberts, 1998, p.2). Networks have a tendency over

time to pull in more and more workers, professions and agencies. Paradoxically, the more extensive the network the more isolated individual workers may feel. Because these networks provide a variety of impersonal contacts with other workers, it is relatively easy to offload unwanted responsibility and concomitant anxiety. When workers get caught up in this "...circulatory system of emotions, especially of despair" (Hinshelwood, 1998, p.24), with its imputations of failures and/or fault, they may find themselves part of a cycle of blame. Care workers at Norfolk House were critical of many, though not all, social workers for being insufficiently available to their young clients and also for not sharing their care plans with the residential staff. Social care was inclined to blame educational parsimony for the failure to provide Kerie with a specialist educational provision and felt let down by CAMHS for not offering her psychotherapy. Very often these cycles of blame involve a perceived lack, or willful withholding, of resources. This sense of chronic deprivation in the network mirrors the experience of the looked after children who are its clients.

One way for a worker to "shy away from lifting more than he can carry" (Main, 1989, p.208) is to let him/herself 'off the hook' by deciding that the type of help the young person requires is of a specialist nature that can only be offered by an 'expert'. (I discuss this defensive tactic further in chapter 6.) So, for example, one member of the residential care team at Norfolk House took the firm view that Kerie needed 'deep, deep counselling'. While this was a valid perspective, it also offered a rationalisation for this worker's half guilty wish that Kerie be transferred to a therapeutic placement. Overwhelmed by a combination of helplessness and fear at the extent of Kerie's neediness and her significant emotional disturbance, this dedicated worker understandably wanted 'to pass the parcel', an impulse which, had she been aware of, would have mortified her. The idea that Kerie needed a specialist residential provision held considerable attraction for the Norfolk House staff team as a whole because they shared a covert but palpable sense of dread that a serious incident, involving violent and/or sexualised behaviour on Kerie's part, might erupt at any time, catapulting the home into scandal. In the focus group interview an RCW expressed this apprehension in relation to another young resident "*... none of us wanted that to happen while the child was here because it's the repercussions for us as an organisation.*" Although in theory idealising the notion of a more appropriate

placement, in practice the staff team found it difficult to feel positive about the alternative provision finally identified by the access to resources team (ART). They criticised both its location (too close to her current placement) and also the timing of the move (too rushed and in the week before Christmas - admittedly an unfortunate time to be obliged to move in with strangers). They also believed that it was not sufficiently specialist to appropriately address her complex needs. Their ambivalence was perhaps in part a reflection of their underlying guilt about 'abandoning' Kerie. Her move also exposed them to a sense of being professionally deskilled and 'not up to the job'. It may also reflect a more general ambivalence towards expertise, which I discuss in chapter 6 in relation to the role of a CAMHS clinician asked to provide specialist reports.

In my contacts with Dermot I observed blame, largely fuelled by feelings of frustrated helplessness, being passed around his support network, myself included. Members of the residential care team criticised the substance misuse worker for 'allowing the wool to be pulled over his eyes' by Dermot. He, in turn, believed that Dermot was verbally bullying and manipulating his social worker. For my part, I felt that Dermot's social worker was projecting some of her feelings of disappointment and failure into me. She recorded in her transfer summary, which she did not send me, that Dermot had been clear about his dislike of his sessions with me and that no follow up therapeutic work had been offered to him after my assessment. My immediate response on reading her summary was very defensive: had I not tried to explore with Dermot the opportunity of having counselling or psychotherapy and had I not recommended this in my report? Again, I had not sensed in him a dislike of our sessions but rather an understandable ambivalence about addressing painful issues. I felt that my work with Dermot had been attacked and dismissed and wondered if this was a way for the social worker to unconsciously rid herself of a sense of failure as well as, perhaps, a rather envious attack on skills differentiation, specialisation and expertise. As she had already left the department there was no opportunity to discuss and possibly resolve our different perspectives. I was left extremely reluctantly holding the parcel, in this case a toxic cocktail of frustration, irritation and resentment. I felt I was a scapegoat.

### **3.5 Taking sides and ganging up to scapegoat the outsider**

The distinction between a 'group' and a 'gang' state of mind (Bion, 1961) is relevant to a consideration of the psychosocial processes taking place in professional networks. The former corresponds to the depressive position and the latter to the paranoid-schizoid position. At both intra-psychic and interpersonal levels, those in a group state of mind will be able to "...tolerate, explore and value difference, alternative viewpoints and the tensions and potential for creativity these throw up" (Canham, 2002, p.113). They will recognise both their own and other people's ambivalent feelings and vulnerabilities. Campbell (2009, p.7), however, highlights "...the struggle multi-agency teams have to listen to each other when the multi-agency colleague is saying things we don't want to hear." (His comment echoes the title of my dissertation, 'Don't shoot the messenger'.) Overwhelming anxiety, including that which accompanies intense uncertainty, can tip people over into a state of mind more aligned to a gang formation, with its illusionary promise of providing safety through the acceptance of a 'handed down', familiar position, rather than embracing 'negative capability'. When workers opt to defend alternative, possibly opposing, positions and try to push through unilateral decisions, professional networks become increasingly polarised and fragmented, as they do also when competing feelings and attitudes, for example idealisation or denigration of a client and/or of colleagues, are held by different workers or different parts of the network.

In such a contentious organisational climate, at any one time some workers may perceive themselves as belonging to an 'in-group', while others may feel marginalised and relegated, either to an 'out group' or, at an individual level, to the role of scapegoat. The ensuing rivalry and antagonism generated between professionals tends to mirror the dysfunctional family dynamics of their young clients, including a pervading sense of being overlooked and bitter sibling rivalry. Chiesa (2000, p.54), for example, comments on "...a growing sense that staff who work in the community are more privileged than those who have been 'left behind' in wards." Hoxter (1983, p.28) refers to "...children's home staff...perceiving themselves to be at the 'bottom of the pile' in social services; they share with the children the feelings of being neglected, deprived of respect and rendered helplessly dependent on 'the system'". An RCW commented how

important it is that “...*the professional doesn't feel that they are instructing us because we are professionals and we know what we are doing and we know how to manage behaviour of complex children*” (RCW focus group, April 2013).

The suspicion felt by the residential care team at Norfolk House towards field social workers, whom they perceived as offering insufficient time and attention to the young residents, in addition to being an oblique expression of their disgruntlement at being ‘left to hold the baby’, was indicative of a sense that their work received scant acknowledgement from better paid, higher status colleagues. Like the young people they looked after, they tended to feel disrespected. It is not just LAC who may ‘bump along the bottom’ (c.f. chapter 4) but also those working closely with them on a daily basis.

Waddell (1998) identifies a prevalence of scapegoating during adolescence, a developmental stage characterised by the competing pressures noted in Chapter 4, on the one hand to conform and on the other to individuate. Both Kerie and Dermot struggled with this conflict. While her personality was rather adhesive and chameleon, he had a more substantial, at times even hopeful, sense of the person he wanted to be. Even so, both young people were scapegoated and bullied by peers. They also ganged up with other residents to pick on whoever in the home seemed most vulnerable at the time. While Dermot managed increasingly to stay on the sidelines, avoiding either role, Kerie found this almost impossible. These dynamics were re-enacted in their professional networks. Several times in my work with both Kerie and Dermot I felt scapegoated and professionally marginalised - ‘sent into the wilderness’ - through informal exclusion from network meetings and other communication channels. I could only speculate about what was so unpalatable in my communications and what I might be symbolically carrying on behalf of what were at times rather dysfunctional and paralysed professional networks. My inability to establish a reasonable working relationship with Dermot’s social worker, who was ‘gatekeeper’ to the professional social care network and main communication conduit between its members, had a significant and lasting negative impact on my visibility and, therefore, effectiveness in the wider network.

There were also times in Kerie's professional network when individual professionals and/or various parts of the network, instead of valuing and being able to work with the different positions that emerged in attempting to make sense of her complex presentation, pulled in different directions, defensively 'ganging up' within their agencies and/ or professions to attack alternative perspectives. The result was a marginalisation and scapegoating of anyone who articulated an alternative position and a related wish to avoid isolation by 'taking sides', a form of 'ganging up'. At different times, for example, I felt that I had become for other professionals allied to, or even identified with, either the views expressed by the majority of the residential care team at Norfolk House or the perspective taken by Kerie's social worker. The pressure to take up a 'position' and in so doing close down the capacity to keep thinking in an open, exploratory manner could feel overwhelming. Perhaps this is inevitable if one accepts the invitation to make recommendations that are then available to be taken up or rejected by the various component parts of the professional network.

Within the LAC service different positions were sometimes taken up and played out between fieldwork and ART and also within children's services overall, between social care and education. From time to time within the wider inter-agency network similarly opposed positions were espoused by children's services and CAMHS. One of the starkest gulfs between positions that I encountered (with a few 'honourable exceptions') was between the residential care team, managed by an independent agency, and the field social workers - the two groupings within the professional network carrying most of the 'hands-on' responsibility for the care of LAC. In professional networks supporting young people there is inevitably a risk that adolescent distrust and antagonism towards imposed authority and hierarchy will be mirrored in relations between colleagues. The skilled residential care workers at Norfolk House - who had, until a relatively recent attempt to further professionalise social work, been known as residential social workers - felt that field social workers gave insufficient weight to the significance of their role in the day-to-day care of LAC. As one RWC noted, "*...our role is important but as service providers we don't always feel that other professionals within the social care environment recognise the important role that we do play*" (RCW focus group, April 2013).

## **Summary**

It is not only the external worlds of young people that can be neglectful and at times abusive, the organisational environment of those working with them is often depleted, fractured and fractious. In this climate workers themselves may feel exposed and isolated. This sense of vulnerability can be exacerbated and compounded by the projections of deprived and highly anxious young people. Understandably workers, like their young clients, erect various defensive barriers. Doing things 'by the book' or 'hoping for the best' can be just as dangerous as 'buck passing' or 'turning a blind eye' to the level of disturbance.

## **Chapter 6. Learning on the job, part 1. Providing specialist mental health assessments**

### **Introduction**

In this chapter I continue the exploration commenced in chapter 5 of various ways in which my three final themes ('external worlds revisited', 'internal worlds revisited' and 'when thinking becomes unbearable') apply to those working in the support networks of young people in care. Within this overall context I focus on one aspect of the work: the provision of specialist mental health assessments. My source material for this chapter derives mainly from two focus group interviews undertaken in the course of my research. In section 1, I discuss the role and status of CAMHS clinicians within the multidisciplinary, interagency networks that constitute their working environments or 'external worlds' (theme four). Section 2 relates directly to my fifth and sixth themes, involving an exploration of feelings aroused in professionals and of defences erected in the course of requesting or providing these specialist reports. In this section I explore possible motivations for requesting assessments. I then discuss the responses of both those who request and those who provide mental health assessments to my question about the areas they would expect a competent and helpful report to cover.

### **0.1 Using focus group interviews**

My two focus group interviews explore six broad areas:

- Workers' understandings of types of mental health assessments;
- Reasons for requesting a specialist mental health assessment;
- Qualities of a helpful report;
- The value or otherwise of specialist mental health assessments;
- The potential 'after-life' of a mental health assessment report;
- Characteristics of effective professional networks.

In this chapter I interrogate the data set from my focus groups, comprising the transcripts of my two group interviews, in order to discover whether the material

can be organised in ways that relate to and reinforce the validity of my fourth, fifth and sixth themes. However, before doing so I make a couple of general comments about the focus groups. In Chapter 3, I mention that the interviews reveal both similarities between points of view expressed across the groups and also some differences in perspective between members. Also, as Barbour (2007, p.31) points out, "All comments made during focus groups are highly dependent upon context and are contingent upon group members' responses to others' contributions and the dynamics of that particular group."

#### *Similarities, differences and group dynamics*

I was surprised by the degree of consensus, not only within the two groups, but also between residential care workers and clinicians in relation to some of the main areas of discussion. Both RCWs and clinicians stressed the importance of attending closely to the young people's communications. Three RCWs spoke of hoping to learn from mental health assessments, especially state of mind assessments, "*...the child's perspective and outlook*", "*...how they see themselves...how they perceive the world*" and "*...their way of thinking their thoughts.*" One clinician emphasised the importance of "*...listening to the child...[and] hearing where they are at.*" Another spoke of focusing on the young person's "*...internal world...[and] what their preoccupations are*". There was more or less unanimity of views across the two groups about the qualities that a useful assessment report should possess (c.f. section 2.) In relation to what motivates a request for an assessment, both RCWs and clinicians mentioned anxiety in the referrer. Whereas this was a feature highlighted by the clinicians, the RCWs tended to prioritise their need for accurate, detailed information about adolescents placed at Norfolk House. It is interesting to note that, whereas the RCWs stressed their wish to be provided by social care with more detailed and up to date information than is customarily the case, the clinicians think referring social workers are often overwhelmed by the large amount of unprocessed information in their keeping. While RCWs feel deprived of the information they need to carry out their role, social workers are drowning in undigested information. This demonstrates one type of fracture or blockage in the social support network. It also reinforces the perception that RCSs have of themselves as being marginalised, whereas it could be argued that their role should place them near the centre of networks supporting LAC.

While both groups were generous with their time, gave my questions considerable thought and shared out between them the time available for responses, there were significant differences between them, which I felt related both to their different organisational cultures and also to interpersonal dynamics. The most marked of these differences was the extent and ways in which any disagreements between members were expressed. The RCW focus group (four women and two men), while in general listening carefully to each other and using polite linking phrases - such as, *“Just to add slightly as well...”*, *“One of the things from what x said is that...”*, *“I was going to say what y was saying...and also z picked it up”* and *“I’ll just say two quick words and then I’ll pass it on...”* - were much more ready than the clinicians (a smaller group, comprising one woman and two men) to express differences of opinion. This trait was demonstrated most often in exchanges between the manager and deputy and may possibly have reflected a slight structural tension between the roles of manager and deputy manager in a small, very ‘hands on’ team. Perhaps also, as the two most senior workers present, they felt confident in expressing their views, even when these diverged. Campbell’s (2009, pp.5-6) observation about the conditions needed to enable the articulation of differences suggests a third possibility, *“...they require a staff group that trust each other to value their differences...and to trust each other to become genuinely curious and respectful during conversations when different positions are being explored.”*

The clinicians, on the other hand, were extremely reluctant to demonstrate anything other than consensus. They were exceptionally positive about what anyone else had just said *“...I think you put it very well”*; *“I completely agree with what...is saying”*; *“I totally agree with...’s comment.”* On the couple of occasions differences emerged, clinicians were almost apologetic. One clinician qualified a colleague’s perspective by initially agreeing and then saying *“...but I come to it from another angle. So, yes, but apart from that I would completely agree”*. Another clinician began *“Yes I would agree with both of you but I think also...”*. While the RCWs were passionate and forceful in their views, the clinicians were more hesitant and their contributions were often punctuated by pauses and half nervous laughter when, for example, discussing the need to

manage boundaries around their work and also the expectations of colleagues in the wider network. These differences between the two groups in how they conducted themselves may have several derivations:

- The RCWs work very closely as a team, sharing many of the same tasks, whereas the three clinicians have different professions and all work only part-time in IAT;
- The RCW focus group was 'held' by the presence of the two managers, who might be thought of as offering a form of parental containment;
- The CAMHS focus group could, for two reasons, be considered as being more 'exposed' than the RCW group. Firstly, it was very small and included only one female (a second female clinician was unable to participate because of ill-health.) Secondly, the interviewer had previously been their close professional colleague.

With both focus groups I was aware of the inevitable influence that our relationships outside the interview must be exerting on the responses of participants (Barbour 2007, p.49).

## **Section 1. Border people in a borderland: locating CAMHS clinicians in multidisciplinary, interagency networks**

In this section I explore some of the challenges inherent in the role of a community based CAMHS clinician, a psychoanalytic child and adolescent psychotherapist, working in interagency, multidisciplinary networks. In chapter 2, I refer to any organisational formation, including a professional network, as having a more or less loosely defined 'primary task'. The role of an individual worker within a professional network might be defined as to appropriately carry out her specific allocated tasks, in pursuance of the network's primary task. One of my allocated tasks during the period of my research fieldwork was that of providing specialist mental health assessments. Working in large, very loosely structured professional networks can severely test the worker's capacity to retain a sense of personal and professional identity. Combining a clear and coherent professional role and set of related tasks with a sense of

connectedness to other workers within the network is challenging on a number of counts. Claiming and exercising specialist expertise, for example, can generate either/both a seductive invitation to provide 'magical solutions' (c.f. section 2) and/or criticism for 'pulling rank'. Because professional networks tend to be amorphous, continuously changing formations - unlike for example teams - it is difficult to establish and maintain effective and adaptive working practices that are based on a mutually respectful and tolerant understanding of colleagues' strengths and weaknesses, both professional and personal. Again, large networks incorporate different organisational levels. "Front-line staff may well have a different perception of the organisation they work in from that of their senior managers. Based on the evidence to this Inquiry the differences could only be described as a yawning gap" (Laming, 2003b, pp.5-6). A third challenge for a psychoanalytic child psychotherapist is to identify and adopt ways of working that are recognised as useful by a variety of 'stakeholders' holding diverse organisational and professional perspectives and priorities. Alongside a professional identity, a worker needs to develop a reasonably secure sense of personal as well as professional authority. Mutual respect for different types of expertise and experience and related attention to professional boundaries are also essential to effective networking. As a CAMHS clinician expressed it, "...respect between the professionals as well is helpful, that we are not sort of falling over each other in some form of competition" (CAMHS focus group, January 2014).

### **1.1 CAMHS clinicians as 'border people'**

District child psychotherapists...occupy a difficult place where these separate territories of the public sector and psychoanalysis, with their vastly different languages and customs overlap...[They] are essentially a border people, living on the overlapping edges of these two different worlds...dependent for their survival and vigour on maintaining strong links with both (Shuttleworth, 1999, p.31).

It can be difficult for an individual worker to find her professional 'voice' and specific contribution within the noisy environment of professional networks. Campbell (2009, p.2) argues that "...a large, multi-level, child protection 'system' is so powerful and persuasive at maintaining its own belief system and power

structures, that the ‘still, quiet voices’ of those people who observe children are frequently not heard.” It is important for child psychotherapists, who are trained specifically to ‘hear’ what children and young people are communicating, to find ways for their own ‘quiet voices’ to be heard above the noise level generated by large, sometimes fractious, professional networks. A clinician spoke about how the network “...has often been very fragmented...[workers] are sort of stuck in their little silos doing their little bits of work but not really connecting up” (CAMHS focus group, January 2014). The strain of holding onto one’s professional identity and authority in a noisy, crowded and unstructured organisational environment, rather than defensively hunkering down in a specialist ‘silo’, can leave a child psychotherapist feeling rootless, a border person in a borderland. In this exposed situation s/he needs role flexibility. This requires the ability both to draw close enough to ‘see’ and ‘hear’ intimate communications and also to draw back sufficiently to create a ‘thinking space’ in which she can reflect on and process both her own and other people’s painful emotions and defensive responses.

#### Boundaries and expertise

Issues of professional identity, authority and clarity of role relate closely to boundaries (both helpful and unhelpful), self-management, specialism and expertise. When one clinician stressed the need for clear role boundaries, the others were in full agreement. “You’ve got to be quite boundaried, I think, in terms of what the remit of your involvement is.” Second clinician, “I agree, yes, I haven’t got anything to add on that one.” Third clinician, “I agree with that as well.” (All three laugh.) (CAMHS focus group, January 2014.) This discussion led one of the clinicians to think about a different sort of boundary:

*I’ve had a long career involved in... this sort of edgy area of social work and CAMHS which I find very interesting, that whole sort of border between what counts as social work and what counts as mental health work. But I think there are different skills that social workers bring as compared to mental health professionals and I think those need to be, you know, sort of valued and recognised so that you can bring those perspectives in. And I think, you know, the fact that there are people of different disciplines as well gives those added differences around sort of analytic, systemic or cognitive behavioural or psychiatric types of thinking (CAMHS focus group, January 2014).*

Professional support networks need to encompass a range of expertise in confronting the complexity of their ‘primary task’. The claim to expertise,

including that implied by providing a 'specialist' report may, however, encounter significant ambivalence in the professional network unless earned through the quality of work. One RCW was scathing about a particular report, "...to be honest with you that person didn't know enough about the child to be able to write that kind of report...that report wasn't really demonstrating the real person" (RCW focus group, April 2013). Alongside individual judgements about whether particular claims to expertise are justified, there may also be a pervasive ambivalence, even covert hostility, to the notion of expertise in general. As a recently qualified generic social worker in the late 1970s, trained at the height of 'community social work', I was encouraged by my line manager, an 'old school' psychiatric social worker, to attend a course at the Tavistock Centre called, 'Strengthening the professional component in social work'. Although I found the casework discussions engrossing, I struggled with the course title, perceiving it to be elitist in ambition. Several years later I was employed by a local authority that required workers from several departments to share an extremely large open plan office, the rationale being that this would challenge 'professional elitism'. Obholzer (1993, p.7) describes a similar organisational and cultural aim taken to extremes, "...a clearly discernible policy, unconsciously determined no doubt, but nevertheless present, of denigrating professionalism, experience and expertise."

## **1.2 Professional networks as 'borderlands'**

From time to time I have asked myself whom I represent, at any particular moment, for this or that young person with whom I am working. In a similar way, I have found myself wondering about the extent to which, on different occasions and in varying contexts, I am perceived by the professional network as either a predominantly helpful or a rather persecutory figure. One way I have attempted to make sense of apparent fluctuations in how my interventions, including mental health assessment reports, are received is to relate these fluctuations to oscillations, experienced both by individual colleagues and by the network as a whole, between paranoid-schizoid and depressive positions. I have also attempted to identify factors influencing the degree of integration and associated receptivity that the network is able to attain at any one time. Cooper

and Webb (1999, p.123) propose that children in the care system have a sense of impermanence in relation to their placements which, in combination with the reality of frequently short-term, transitional placements, brings about a state of mind in them and their carers similar to that of a borderline state of mind. It is interesting to think about these young people's professional support networks as having similarly borderline features, in that they are inherently temporary, transitional and shifting phenomena.

Menzies (1977, p. 33) emphasises that "Defences are, and can be, operated only by individuals. Their behaviour is the link between their psychic defences and the institution." Social entities, however, through their organisational cultures may operate in ways that could be described colloquially as depressed or manic, suspicious or fearful, etcetera. Using 'borderline' in its everyday, rather than its clinical, meaning, it is arguable that professional support networks demonstrate several borderline features:

- They are inherently temporary, transitional phenomena;
- While a particular network will be organised around, and more or less defined by, a specific, if rather vague, task such as providing professional support to a young person in care, it does not constitute an organised body of people like, for example, those working in one organisation;
- With their loose structures and tendency to expand randomly, they offer those who work in them very little emotional containment;
- Perhaps most significantly, those working in professional support networks are prone to adopt 'anti-task' ways of behaving. These are defences against intolerably painful feelings generated while carrying out their 'primary task', broadly defined as the care of troubled and troubling young people. When the task is complex, unclear and arduous, moving 'off-task' to find some form of 'psychic retreat' may seem to offer an attractive alternative.

Working with extremely vulnerable young people involves continuous risk assessment. The present economic recession and related political, social and environmental factors exacerbate the already high levels of anxiety generated by this complex, anxiety provoking work:

*...one of the systemic issues...is how we manage and work with the*

*networks because if they become anxious some of the things that they worry about actually can produce the problems and the symptoms that they envisage...It's not just managing the anxiety within the family and containing that but managing it within the networks as well (CAMHS focus group, January 2014).*

Whilst at their most effective professional networks offer some emotional containment for workers under stress, only too often in this respect they are 'unfit for purpose.' It is tempting under these conditions to seek ways of avoiding full confrontation with the emotional reality of the work. In chapter 5, I discuss several professional defences including, 'just get the procedures right'. This defence can produce 'pseudo-clarity of goals' (Obholzer, 1993, p.7). "The borderline is a domain governed by the intense need to *simplify*...structures, and to eliminate uncertainty" (Cooper and Lousada, 2005, p. 51, italics in original). This is a defensive response to the decreasing capacity of contemporary organisational forms to provide effective containment. Also, in organisational borderlands, as in other borderline states, 'shared' responsibility can quickly degenerate into unclear and diluted responsibility, bringing about the paralysis of decision-making and lack of agency described in chapter 5. Waddell (1998, p.128) refers to adolescent anxieties about identity that are capable of provoking "...an acute intolerance of difference, either in the self or in the other". In a similar way, chronic anxiety in the professional networks supporting those adolescents can generate intolerance of differentiation. It is important, though not always straightforward, to distinguish the state of integration from that of being stuck together. In the former state, acknowledgement of difference fosters genuine collaboration and creative links, as in 'joined up thinking', while in the latter state there is essentially no movement. Those working in support networks may 'catch' from their young clients a typically adolescent suspicion of difference. They are vulnerable also to taking on, through projective identification, other adolescent characteristics such as competitiveness and a preoccupation with status (Dartington, 2010, p.33). These traits, stoked by environmental pressures to attribute personal blame for systemic failures, may eventually become embedded in a perverse culture of mutual suspicion, blame and recrimination that is anything but containing "The focus of complaints procedures, investigations, and inquiries is on individual workers, and this sets up a culture that runs counter to teamwork and cuts across it" (Foster, 2002, p.93). The RCW focus group threw up an

example of this type of perverse culture in action. Speaking about the impact of one young boy placed in Norfolk house, an RCW described how:

*...our resources and staff were run ragged because obviously you didn't want anything to happen because of the nature of the child's behaviour and the risk that it posed, it potentially posed, to the other young people but we just didn't get the support...And the reality is not everyone is honest and they would say 'deh de deh de deh' people can be creative with things. We weren't going to allow that to happen to us as an organisation. And so a decision was made. And none of the professional network agreed with the decision that was made but nobody could do anything to change it...though we missed the child, we were glad when the child moved on because we no longer had the responsibility, serious stress and anxiety (RCW focus group, April 2013).*

In chapter 3, I refer to the dysfunctional 'second skin' defences of children who have not been able to internalise a vital sense of emotional containment. As a consequence they lack a secure sense of their own boundaries and hence identity. Cooper and Lousada (2005a, p.47) argue that each arena of activity (system) in social care needs a boundary or 'skin' - as do children and people in general - which, while sensitive to external influences, is also strong enough to protect its internal life. To be 'skinless' exposes the 'system' - individual worker and/or profession and/or organisational form, including a professional network - to the risk of losing a secure identity. Such a deprivation is another central feature of a 'borderline' state'. As frontline workers struggle to retain a sense of purpose and integrity, managers may increasingly disengage, falling back on what Obholzer (2000, p.ix) refers to as the 'clarity of blindness':

The front-line workers are too caught up in attempting to maintain their self and emotional survival to be able to reflect on what they are caught up in, the rearguard workers 'know' what is going on with a 'clarity of blindness' that comes from never going near the coalface of the workplace and further distancing themselves from the pain of engaging in the all too familiar game of 'them and us'.

Cooper (2010, p.223) describes a related dynamic through which managers, by turning outwards to engage with the organisational environment, leave frontline staff unsupported and exposed.

One consequence of contemporary organisational forms shedding hierarchical management structures and transforming themselves into networks is that instruction tends to be replaced by negotiation, the locus of authority becoming more diffuse and elusive. In this emerging organisational environment, the

function of organisations as containers for employees' dependency needs is thrown into question:

As organizational life is now configured and experienced, there is frequently no longer a *structure* of "parenting" either for organizations or for those working within them, that can perform the kind of psychic work assumed to be necessary by traditional theory (Cooper and Dartington 2004, pp.143-144, italics in original).

Workers face the challenge of learning to contain and process their own anxieties in order not to be overwhelmed and disabled by them.

## **Section 2. Requesting and providing mental health assessments**

My fifth theme, 'internal worlds revisited', introduced in chapter 5, relates to various ways in which feelings of vulnerability, anxiety and deprivation are transmitted from severely disadvantaged and troubled young people to those working with them. In the current chapter I identify how its two sub-themes, 'left holding the baby' and 'shell shocked', with their associated feelings of isolation, suspicion, alarm and temporary panic, may at times underpin the request for a specialist assessment. One RCW expressed her perception that "*We get restricted, little information on a child...the alarm bells are going off...and its like, whoah, we didn't know about this.*" And again, "*I have always felt as if information is withheld to see if we have picked up...why didn't we know?*" There may be a pervasive sense of isolated, mutually distrustful workers trying to 'stay afloat' in a conflictual and risk adverse organisational culture that prioritises self-preservation (c.f. section 1). Troubled and troubling feelings evoke a wish to construct defensive barriers. My sixth theme is 'when thinking becomes unbearable'. One or more of its sub-themes - 'busyness', 'just get the procedures right', 'ways of looking away', 'passing the parcel/buck' and 'defensive ganging up and scapegoating' - frequently form part of the motivational mix for requesting specialist mental health assessments. Mutual suspicion and antipathy, for example, may lead to defensive, ultimately disabling, splitting and fragmentation in the support network. This in turn may

trigger passing the buck, ganging up and scapegoating. Parsons and Horne (2009, p.45) refer to workers who are not so much seeking a genuine assessment of risk as trying to enlist an 'expert' opinion to add weight to their pre-existing position. This could go some way to explaining a clinician's concern about "...*whether their [social care] assessment chimes in with ours*" (CAMHS focus group, January 2013). Main (1989, p.20) describes referrers who "...asked for help for the patient of the kind they had devised, and wished to leave so little choice to us that it seemed as if we had to be their omnipotent executive organ". Whenever these perverse dynamics infect the referral process, they can also distort the way in which recommendations made in specialist reports are perceived and received (c.f. the title of my dissertation). The reception by their respective professional networks of the mental health assessment reports I wrote about Kerie and Dermot provide examples of how 'expert' recommendations can be 'kicked into the long grass'. Of the six recommendations I made in relation to Kerie's psychosocial needs, four were eventually taken up, while to my knowledge the remaining two were never carried out. In Dermot's case, out of my eleven recommendations, one was partially taken up, one was not applicable because it related to a prospective foster care placement that did not materialise, while the other nine were not pursued. One RCW spoke despairingly of her frustrated wish to have the recommendations from a particular specialist mental health report "...*heard...and followed through, not just by us but by other key professionals...CAMHS or whatever may make a recommendation but the (IAT) team may think something completely different*" (RCW focus group, April 2013). A clinician commented on his defensively proactive strategy to minimise the risk of his assessments being disregarded:

*...when the report is written, even if the social worker doesn't want to necessarily follow it up... I tend to follow it up with them anyway. I make a point of having a meeting to go through the report to get their agreement because what might be agreed at one point and understood and what they have agreed to, they might change their mind at some point down the line* (CAMHS focus group, January 2014).

I refer in chapter 5 to my occasional sense of isolation and marginalisation within and by the professional support network, a feeling articulated by RCWs several times during their focus group interview. One of the clinicians also spoke of feeling at times, in relation to his assessments and the

recommendations stemming from them "...*somewhat ignored or not really consulted to*". This may result from expressing in a report unpopular and/or uncomfortable opinions that challenge the status quo. When this happens it is tempting to 'take sides', to accept the implicit invitation to 'gang up' and join the 'in-group' (c.f. Main, 1989, p.25). This impulse stems from anxiety about of being isolated and perhaps scapegoated. Emanuel (2002, p.176) comments on how "... the fear of becoming the hated object may permeate all the way up and down the system". She proposes that such a dread might be understood "...as a counter-transference experience, a powerful communication via projective identification into the professional of the child's experience" (ibid). In writing up my mental health assessments, and especially when framing my recommendations, I was very aware that "When representatives of different professions take conflicting views of the same situation...they are unlikely to resolve their dispute by reference to facts or judgements of the relative effectiveness of actions" (Schon, 1987, p.218). Schon urges professionals to attempt to "...get inside each other's points of view" (1987, ibid) (c.f. Campbell, 2009, on positioning theory). This effort, however, presupposes a state of mind conducive to thoughtful discussion rather than one that holds onto rigid positions as though they are lifebuoys in a rough sea, which is probably how they are unconsciously perceived. For all the reasons enumerated, this state of mind, which approximates to the depressive position, is hard to maintain in the uncontained and uncontainng organisational climate of many contemporary professional networks. Having sent my reports to the referrers and other key professionals in the young people's support networks, I struggled to create opportunities to discuss them in person, and only rarely succeeded in bringing together more than one or two colleagues to think together about how their recommendations might help to inform care plans. The feelings described by one RCW echo my own at those times when the links in the support network seemed to have come apart:

*I was in a recent meeting about a young person. A state of mind assessment was done and the recommendations at the end were completely dismissed. It was like 'what's the point of the young person going through the process and for every key professional to know what he needed - we all agreed with what he or she needed...the department completely dismissed that report and the young person didn't get what he needed and that seemed a complete waste of time (RCW focus group, April 2013).*

When I asked RCWs their reasons for wanting specialist mental health assessments, they responded initially with an impressive list. Such assessments can: challenge assumptions about what is going on for a young person; facilitate more objective, evidence based assessments; provide information about ways to support a young person; provide a young person, and potentially their carers, with a voice; enable those currently caring for the young person to 'get up to speed' with the young person's state of mind; and allow other professionals to contribute both during and after the assessment, in this way encouraging networking.

Their enthusiastic endorsement in principle of specialist assessments was, however, qualified by some less positive experiences 'on the ground'. One RCW intimated that in reality they are unable to formally request such reports, something only social workers can do. While challenging this perception, another worker felt frustrated that *"...though we request assessments, it takes an extremely long period of time for an assessment to take place."* The RCWs felt they often received only partial information about the subjects of the reports, which made them feel that the value and difficulty of their work was largely unrecognised by other professionals. Finally, there was a sense that some specialist mental health reports:

*... are very similar to ours. Something we might have said 6 months ago has taken 6 months for someone else to say... But because it came from a different agency it was 'Oh my God'. It was all highlighted...it took somebody else of a more professional nature for them to recognise what we here had done (RCW focus group, April 2013).*

The CAMHS clinicians, who provide specialist mental health reports, hesitated before responding to my question about what motivates a referral. (There were many more silences, pauses and hesitations in the CAMHS focus group than in the RCW focus group. The latter tended to 'jump in' energetically, sometimes interrupting each other's responses.) One Clinician commented:

*I think it is at times genuine, you know, they genuinely want to do the right thing by this person and feel that they need a specialist assessment to try and help find the right kind of support... I think it comes from a good place (CAMHS focus group, January 2014).*

Both focus groups identified anxiety as an important trigger for requesting specialist mental health assessments. The RCWs took the view that a specialist

mental health assessment was warranted when a young person's disturbed behaviour, for example self-harming, causes concern in the home and/or in other contexts such as school. Clinicians were of the opinion that referrers sometimes found it difficult to analyse, to *'think around'* the information they had access to, and/or believed, rightly or wrongly, that this was so. Lord Laming (2003a, p.238) opines that "Seeing, listening to and observing the child must be an essential element of an initial assessment for any social worker". In reality, however, "...sometimes there is a genuine lack of understanding, lack of knowledge of what's in front of them because they just don't have the same training, they don't have clinical training"(CAMHS focus group, January 2014).

Referrals for specialist assessments are frequently precipitated by crises, at which times action tends to take precedence over thoughtfulness. (I give an example in chapter 5 of my collusion with this drive to activity.) Alfille-Cooke's (2009, p.63) observation that a referral may be made to several agencies "...in the hope that one might come through" mirrors my own experience, as well as that of a clinician I interviewed, who commented "...for many of these families it can feel like *'death by assessment'*, they can end up with too many assessments." Another clinician talked about how "We still do get, especially from inexperienced social workers, a sort of blanket bombing approach to bringing in all and sundry to the situation". The desire to 'cover one's back' by getting the procedures right can also lead to empty, self-defeating busyness. In the professional networks in which I worked, the considerable time and energy I and others expended in trying to follow the correct referral procedures, in the correct order, as well as ensuring all the appropriate professionals were involved or informed, contributed significantly to the delays in progressing care plans about which I write in chapter 5.

## **2.1 The wish that clinicians 'make things better with their therapeutic wands'**

*Social services colleagues...have great ideas...about how we can sort of cure children of what, you know, the difficulties, try to make things better with our therapeutic wands and it's not possible really. And it's just sort of, you know, the work of sitting with the difficulties. And I think a lot, certainly*

*my experience is that social services really struggle with that.* (CAMHS focus group, January 2014).

The same clinician went on to reflect on how the disappointment may be passed on, *“And then I think we feel, we can, you know, that’s projected into us, and we feel a bit useless”* (CAMHS focus group, January 2014).

Most workers, unless in the grip of a manic, omnipotent state of mind, will from time to time be confronted with situations which they recognise as severely testing their individual skills and experience. They may, therefore, approach a professional or an organisation holding the relevant expertise. There can, however, be a fine line between a realistic recognition of the need to enlist specialist skills and a wish to hive off the task, to ‘pass the parcel’. Foster (1998b, p.85) refers to “...an unspoken but powerful expectation...placed on professionals whose job it is to care for the mentally ill in the community: that they will make mental illness disappear, either by curing the clients or by making them invisible.” In response to this underlying societal pressure, a reality based strategy can easily slide into a much more defensive one in which a worker feels a need, of which s/he is not fully aware, to pass on the burden of engaging with an extremely difficult emotional reality. Parsons and Horne (2009, p.45) observe that “...some referrers may feel so overwhelmed with anxiety and helplessness that they hope that someone else, or another agency, will take away their anxiety by taking responsibility for the patient and by providing solutions”. Schon (1987, p.252) makes a similar point in referring to the “...magical expectation of her therapist...” placed on the psychoanalytic clinical supervisor by his/her supervisee, which mirrors that placed on the supervisee by her own clients/patient’s. If an anxiety provoking, problematic issue can be handed over it is then temporarily placed out of sight/out of mind. This is an ordinary defence in which many of us take refuge when feeling out of our depth. A CAMHS clinician commented, *“I think there can be myths around what we do and what we don’t do”*. It can be useful to hold onto such a myth. “The process...that is labelled ‘referral’ could in reality often be better described as disposal, where referral may be observed to be not so much the referral of the problem as the dumping of a person” (Dartington, 2010, p.91). The ‘expert’ or specialist who is ‘dumped on’ is expected either to offer a quasi-magical solution

or else to carry the psychological guilt and disappointment of failure:

*“If you are the person that people turn to when there is a crisis and you are expected to have the answers, that takes it slightly, you know [Responsive laughter from the two other clinicians in the focus group.] Things get out of hand”* (CAMHS focus group, January 2014).

At times in my own practice I thought I recognised an element of wish fulfillment in a request from social care to IAT to provide an assessment report on a young person, a hopeful expectation that what the latter needed and would receive was the ‘solution’ of individual therapy. The consequent sense the referring worker may have of being deskilled through carrying out this defensive manoeuvre is a type of ‘collateral damage’. One of the clinicians spoke about his awareness of this danger and how, as the ‘expert’, he tries to address it, *“...sometimes social workers feel they haven’t got the skills to be able to sort of analyse the data that’s coming in. Sometimes it’s a matter of actually reassuring them that they actually do have the skills”*. This clinician’s reflection resonates with that of Parsons and Horne (2009, p.45), who stress the importance of *“...feeding back in a digested form to the referrers and engaging with them in discussing the case. This will enable the referrers to feel more confident about what they probably already know at some level.”*

## **2.2 The potential value of specialist mental health assessments**

I explored, both with those who request and those who provide specialist mental health reports, how much value they accord to such assessments. I also asked both focus groups to name some characteristics of a helpful report. The participants in both groups gave carefully considered, thoughtful responses, drawn from professional and personal experience (c.f. Polanyi’s concept of ‘personal knowledge’ which I discuss in chapter 3). One RCW stressed that *“A good report would consider children’s wishes and feelings...first and foremost.”* She emphasised the need for the report to provide background information and to note the impact of work already carried out, as well as any significant improvements the child had made. She also felt it should be forward looking and include:

*...a plan that flows, not just a report that is written and then it becomes a dead document...The report needs to follow the child...It needs to stay live, it needs to be worked on, it needs to be reviewed. The child needs to go along with it and I don't always think that happens (RCW focus group, April 2013).*

She talked movingly of the need to 'hear' the child and to appreciate the extent of their vulnerability:

*...from the child's perspective I think it is important that...the child is heard but thinking from a child who willingly engages in this, they are vulnerable first of all. So it's about trust and about openness. They have exposed themselves.*

Another RCW wanted an assessment to recognise the value of ongoing work, "Some of the time we do the work anyway but it would be good to have a confirmation of that." (Her remark echoes feelings, already noted, that the important job of 'holding the baby' on a day to day basis is undervalued.) She viewed an assessment as beneficial because "...it allows the young person to have a voice" (RCW focus group, April 2013).

When I asked the CAMHS clinicians to describe a 'model' CAMHS mental health assessment report on a LAC, one they would consider of value to front-line social care professionals, they initially thought I was asking what *they* would expect from reports they *received* rather than ones they themselves wrote. All three agreed that they would value an up to date and accurate chronology and history. This hopeful expectation reminded me of the frustration expressed by the RCWs for not being provided with detailed and timely information about the young people placed with them. Reflecting on the desire of both clinicians and RCWs to have this type of information I tend to understand it, in part at least, as representing a wish for order to be imposed on what are in reality complex, confusing and chaotic narratives which more or less accurately reflect the lives of those about whom they are written. Once I had clarified that my interest was primarily in the reports *they themselves* wrote, one of the clinicians again stressed the importance of a detailed account. A report should include:

*...a forensic family history...maybe the use of a genogram which might be an expression of those problems that maybe have gone on for a number of generations...bringing it all together in a formulation that helps the social worker in the report that they are given...and also gives a structure or a plan of work in conjunction with other services...*

Another clinician talked about holding in mind who will receive the report, “*You have to sort of put yourself in the position of the person who is reading the report...so it needs clarity...the key thing is to provide a clear analysis of the information and try to make sense of what is happening.*” This view was supported by the third clinician, “*...our job is to try to write reports that lay people can understand, that are meaningful, really*” (CAMHS focus group, January 2014.) The identification of accessibility, clarity and structure as three key elements in a ‘good enough’ report may contain a quasi-magical wish to tidy up an elusive and messy reality (Schon 1983), as though they could mitigate the emotional impact on workers of the disturbed and disorganised lives that are depicted in the mental health assessment reports. More importantly, however, as Parsons and Horne (2009, p.45) point out:

Pulling all this material together...can offer the first step in containment, not only of the likely risk but also of the patient, whose needs can be expressed through raising increased anxiety within the network, and of the referrer who is subject to such projection.

This containment is extremely helpful, if not essential, in the context of work undertaken in large, loosely organised, sometimes fractured and occasionally fractious professional support networks. As one clinician pointed out, “*...it prepares the network, rather than thinking that they are dealing with chaos all the time*” (CAMHS focus group, April 2013).

## **Summary**

Analysis of my focus groups revealed that often part of the underlying motivation of a request for a specialist mental health assessment is to alleviate anxiety by identifying an expert who ‘has all the answers’. Conversely, residential care workers also gave thoughtful examples of ways in which enlisting specialist support had enabled them to work more effectively with young people in their care. Similarly, clinicians felt there were times when they were expected to ‘make things better with their magic wands’, and expressed apprehension about being flooded with unrealistic demands generated by the high levels of anxiety among social care workers. Both RCWs and clinicians emphasised the need for greater communication between those who request and those who carry out mental health assessments. Clinicians, however, felt

that even when appropriate referrals were made, their recommendations were sometimes 'left on the shelf'.

## **Chapter 7. Conclusions: the limitations of help**

### **Introduction**

I have borrowed the title of my concluding chapter from Britton (1981, p.53, italics in the original). Having stated that:

...families whose mode of mental operations are characteristic of the '*paranoid-schizoid*' position rather than the depressive position...are likely to evoke unconsciously determined action in those around them. [and frequently]...become the chronically unsatisfactory cases of social services...

he proposes that "...the painful discovery of the limitations of help...may lead to the possibility of taking uncomfortable but necessary steps or accepting small, significant changes rather than cherishing unrealized hopes for a transformation" (1981, p.54). This encapsulates for me both the challenges inherent in the type of work discussed in my dissertation and also a state of mind that I believe is important to cultivate in this work. While my research focuses on the value or otherwise of specialist mental health assessments to those working to support 'looked after' adolescents, I broaden my analysis to take into consideration the challenges inherent in working within professional networks. In order to extend my understanding of these issues I have drawn extensively on a range of relevant literature, mainly psychoanalytic but also systemic and more general. This concluding chapter is organised around four related questions. In section 1, I address the relationship between my research aims and findings. In section 2, I ask how well my methodology and research design complement my research questions. Section 3 explores some potential implications of my research. I conclude by considering a number of ways in which my research findings could inform practice, policy and research.

### **Section 1. The relationship between my research aims and findings**

In chapter 1, I gave as my overall research aim that of exploring some of the conditions that either facilitate or disable effective professional networks and networking. I undertook to do so through an exploration of the processes and

dynamics involved in undertaking and disseminating specialist mental health assessments. My intention has been to identify processes operating within multiagency and interdisciplinary systems that influence the extent to which such assessments can help to achieve desired outcomes for troubled adolescents in the care system. I hope that this will contribute towards an understanding of the impact and usefulness, or otherwise, of specialist reports in a networked social welfare culture.

My overall research aim encompasses several interrelated areas of questioning. One relates to the extent to which intra-psychic and psychosocial difficulties experienced by many 'looked after' adolescents are mirrored in their professional support networks. Another asks whether, and if so how, the uses to which reports are put vary according to the individual and collective states of mind generated within professional networks. A third area of questioning relates to the reasons prompting requests for specialist mental health assessments. Whose needs are met by these assessments and in what ways? I have attempted to address these three questions throughout the research process. Other more specific questions, including that of which areas workers would expect a mental health assessment to incorporate, are explored mainly through my two focus group interviews.

My research questions have been prompted by several hypotheses or working assumptions that I had developed over time through reflecting on my experiences at work and was keen to interrogate. I anticipated that while some would be confirmed by my findings, others would need to be modified or rejected, and yet others would prove to be valid but of little relevance to my research questions. They are as follows:

- Requests for specialist mental health assessments relate significantly to the high levels of anxiety particular young people can generate in professional support networks;
- These requests may involve an element of defensively turning to 'experts' who are expected to provide magical solutions to severely anxiety provoking, possibly intractable, problems;
- Acceding to such seductive appeals may lead to those in the 'expert' role unconsciously colluding with tendencies in professional support networks

towards taking up fixed positions, polarised views, splitting and fragmentation;

- Finally, underpinning both my theory and methodology, psychoanalytic theory can be usefully applied not only to the study of intra-psychic but also of interpersonal and organisational relationships.

I take heart from Bion (1970, pp.79-80):

...thanks to Freud and his co-workers ordinary people hope by psycho-analysis to be able to illuminate the mind. The fact that the world's work has to be done by ordinary people makes this work of scientification (or vulgarization, or simplification, or communication, or all together) imperative.

Whitehead and McNiff (2006, p.29) advise the researcher, "If ever you get stuck on the word 'theory', try replacing it with 'claim to knowledge' or 'explanation'". I have sought to provide a theoretical framework that can help to explain the high anxiety levels frequently experienced by those working in professional support networks, an emotional disturbance which I argue is generated by their close contact with troubled and troubling young people. "Somebody once described a theory as a system for containing anxiety - containing in the sense used by Wilfred Bion, and thus meaning reducing anxiety and giving us a sense of being held" (Obholzer, 1994a, p.1). I hope that my research contributes towards containing - through understanding - some of the intensely painful feelings that ricochet around professional networks and which may understandably provoke an array of ultimately counter-productive defensive manoeuvres. Rather than seeking to establish unilinear causal relationships, I have attempted to identify meaningful connections between phenomena across three different levels: intra-psychic, interpersonal and organisational.

In chapters 4, 5 and 6, through analysis of my case studies and focus groups using a grounded theory approach (discussed in section 2) I identify six linked themes, each having at least two sub-themes. I argue that these themes can be discerned not only in troubled and troubling young adolescents in the care system (chapter 4) but also among those working in their professional support systems. I further argue that within these systems, known generically as 'the care system', the same broadly defined themes that can be identified among individual workers can also be discovered at the organisational level (chapters 5

and 6). As Britton (1981, p.49) observes, "The cast changes but the plot remains the same". My six themes fall into two groups of three. The first group describes the external and internal worlds of many LAC and their defensive responses to the unbearable nature of both of these. I have called them:

1. External worlds: childhood deprivation, abuse and multiple dislocations;
2. Internal worlds: the devastating psychological impact of severely adverse formative experiences;
3. Minds like minefields: survival tactics in a world shot to pieces.

The second group of three themes describes the external and internal worlds of those who work in professional support networks and the defensive barriers they erect to ward off the painful projections of the young people with whom they work. They are:

4. External worlds revisited: working in risk adverse, depleted, sometimes fractured and fractious professional networks.
5. Internal worlds revisited: whose feelings are these anyway? The transmission of vulnerability, anxiety and a sense of deprivation.
6. When thinking becomes unbearable

Their names have been chosen to underline the way each theme in the second group of three mirrors a particular theme from the first group. Theme 4 has close links with theme 1; theme 5 links to theme 2; and theme 6 with theme 3.

In relation to my first question about whether and/or to what extent professionals both individually and collectively mirror the states of mind of the young people with whom they are working, my thematic analysis has provided detailed evidence to support the proposition that close contact with troubled and troubling young people creates significant emotional disturbance in those working with them. I have demonstrated, moreover, that it is the intense anxiety generated in workers that triggers many requests for specialist assessments as well as influencing how specialist reports are received and used within the professional networks. If/when the motivation for requesting a specialist assessment is to alleviate anxiety by passing it on rather than to confront and address the causes, the needs of the young person who is the subject of the report may take second place to those of the worker. Through reflecting on my own counter-transference feelings, as well as by drawing on recorded observations, I have also been able to give examples of those holding specialist

roles accepting the seductive invitation to occupy an albeit temporary and fragile pinnacle as an 'expert'. Taking up a position that supports the perspective of one particular part of the network can lead to polarisation and splitting. Conversely, my analysis has also revealed that when professionals are in less anxious states of mind they may seek an expert opinion, not as a way of passing on acutely uncomfortable and unwelcome feelings, but rather in recognition of the value of skills differentiation, alternative viewpoints and collaborative working practices. The final hypothesis I wanted to interrogate was that psychoanalytic theory is helpful in understanding these processes and dynamics. While the psychoanalytic paradigm underpins my research in general, I have drawn especially on a small number of concepts derived mainly from object relations theory.

#### *The paranoid-schizoid and depressive positions*

I have found of especial value in my research the depiction of the dynamic qualities of these two positions. These include not only the continuous oscillations between the two positions but also the notion that there are gradations within each position, for example the fluctuations in degree of integration and levels of ambivalence within the depressive position. I have attempted to trace these processes operating at different levels: intra-psychic - both in individual young people and in individual workers -, interpersonal and organisational; and discovered a correspondence between a sense of integration within the professional network and the ability to recognise and express differences in a non-hostile way.

#### *Projective identification*

I have argued that the mechanism by which unbearably painful aspects of the internal world of an extremely troubled young person, such as Kerie or Dermot, are transmitted to an individual worker and also lodged at an organisational level in the professional network is that of projective identification. Horne (2001, pp.15-16) draws attention to how "...the internal world of the offender patient is realized in the network where we repeat the functions and attitudes of internal objects and 'willingly' reinforce unhelpful defenses".

### The 'primary task'

Throughout my research study I have attempted to address the question posed by Armstrong (2005, p.101): "...faced with evidence of group mentality in organizational functioning, no less and no more than when we are faced with evidence of individual pathology, we need to ask and be alert to the question: why?" Armstrong's question presupposes another, one that asks about the purpose or 'primary task' of a professional support network. Stokoe (2003, p.96) offers as a working definition for the primary task of a therapeutic community "...to enable the development of each young person". While at one level the primary task of a professional support network could perhaps be defined in a similar manner, the 'devil is in the detail'. Unlike therapeutic communities, networks lack clear boundaries and defy neat categorisation. Clarity of task eludes most professional networks, which tend instead to have many and varied, sometimes conflicting, tasks and priorities. Without a clear primary task it is extremely difficult to achieve a collective 'work group' frame of mind, one focused on carrying out realistic work tasks (Bion, 1961). Instead, those comprising the professional networks are susceptible to any number of unconscious 'anti-task' defensive tendencies, including those described in chapters five and six. I think that Dartington (2010, p109), in referring to the aim of an integrated health system, provides a good working definition for the primary task of professional support networks. He argues that, "Integration is about making a society fit for the most vulnerable members of that society - the ill, the disabled, the disadvantaged - to live in".

Kuhn (1996, p. 24) describes what he terms 'normal science' as:

...an actualization achieved by extending the knowledge of those facts that the paradigm displays as particularly revealing, by increasing the extent of the match between those facts and the paradigm's predictions, and by furthering articulation of the paradigm itself. Few people who are not actually practitioners of a mature science realize how much mop-up work of this sort a paradigm leaves to be done or quite how fascinating such work can prove in the execution.

His notion of "mop-up work" recalls Schon's (1983, p.43) description of the researcher 'muddling through' in a terrain characterised by 'swampy lowlands'. These depictions of the research enterprise resonate both with my modest

research ambitions and also with the satisfaction I have received from the research process itself, which Kuhn (1996, p.35) calls 'puzzle solving'.

### **1.1 Discrepancies and inconsistencies**

As noted previously, I had anticipated that some of my working hypotheses would be challenged by my research findings. In the event, all were very broadly confirmed. Kuhn argues that, while the outcomes of what he terms 'normal research' can very often be anticipated in detail, "...the way to achieve that outcome remains very much in doubt. Bringing a normal research problem to a conclusion is achieving the anticipated in a new way" (1996, p. 36). I hope that my research affords an example of this process. While, however, the overall outcomes of my research could have been anticipated, at another level, the research threw up many discrepancies and inconsistencies. According to Barbour (2007, p.47) "...qualitative research thrives analytically on differences and discrepancies... Rather than agonizing about contradictory findings as a problem, we should be engaged in using these as a resource." My research has focused on the intensely painful emotions, together with the dysfunctional defensive responses these frequently generate in both young people and those charged with their care. I do not apologise for this because I agree with Armstrong's (2005, p.109) contention that "No emotional experience in organizational life is a suitable case for treatment. Rather, a resource for thinking, for releasing intelligence." On the other hand, my reflective case studies and focus group interviews also provide evidence of a variety of positive qualities and strengths in both young people and in those who work with them, most notably hopefulness, agency and the ability to use projection as a means of helpful communication. Youell (2002b, pp. 126-127) comments on how some people, both adults and children, who have been deprived and traumatised "...manage to hold on to something hopeful; some part of the personality remains open to an experience of containment". This was certainly my experience of Dermot, though towards Kerie I felt much less hopeful. Each adolescent is unique, with different capacities for integration and resilience. Young people like Kerie and Dermot tend to feel, at a level beneath consciousness, that they simply can't afford to hope because the cost of being

let down yet again would be too high. This sense of 'not going there' may in turn creep over and paralyse the professional support network, as my case studies demonstrate. Dermot, however, was at times in touch with a sense of hope, encapsulated both in his positive memories of childhood holidays in his parent's country of origin and also in his plans and prospects for the future (When I met him again three years later in order to ask for his consent to being a research participant he was on his way to realising at least some of these.) Although he probably had an idealised notion of an accepting, caring extended family 'home base' that was in reality absent for most of his childhood, I felt his capacity to retain this image was indicative of his emotional resilience. There was a fairly fine but nevertheless discernable line distinguishing Dermot's hopefulness from Kerie's bouts of manic optimism. He, like Kerie, could flip over into a state of excitement mixed with grandiosity and/or express a manic optimism, which flew in the face of a bleak reality. However, along the borderline between healthy and psychotic he retained a firmer foothold than Kerie on the healthy side of the boundary. Likewise, Dermot's exercise of agency and capacity to be proactive was more substantial than was Kerie's. He was, for example, the only young person out of my initial sample of six to respond directly to my request for their participation in my research project.

Kerie and Dermot were both able at times to powerfully project their feelings in ways that facilitated communication rather than as hostile evacuations or attacks. During one professionals' meeting Kerie was able to communicate effectively her deep sadness and increasingly desperate sense that she was not being listened to and understood by the adults. I found myself moved by her words and her way of expressing herself. I sensed that she was, albeit temporarily and fleetingly, filled with depressive rather than persecutory anxiety. Sometimes when I talked with Dermot, although - or perhaps because - he seemed so keen to give me an impression that he was able to look after himself, my counter-transference feelings were that he needed care and protection. Both young people also had some capacity to symbolise. I have commented previously on Kerie's role-play on a computer game in which a small, isolated and embattled cartoon character felt to me to be symbolic of Kerie's self-image. Dermot likewise, through his drawings in our sessions, was

able to communicate symbolically a great deal about his feelings and self-image.

Professionals also demonstrated a range of positive emotions and non-defensive responses including qualities of realistic hope and agency, evidenced mainly through the case studies; as well as compassion and thoughtfulness, evidenced mainly through the focus group interviews. Such qualities help to build resilience in the face of ongoing challenges to integrated ways of thinking and forms of practice.

## **Section 2. Evaluating the fit between my research questions, methodology and research design**

My specific research question relates to the identification of those intra-psychic and psychosocial processes which influence the variety of ways in which specialist mental health assessments are received by those working in the professional support networks of 'looked after' adolescents. This question is embedded in a wider exploration of the dynamics operating in organisational networks. In order to explore these related questions I have adopted a grounded theory approach that aims to engage in a type of inductive theory building within a largely psychoanalytic paradigm. As a researcher/clinician, I have adopted a 'real time' approach and a naturalistic, emergent research design. In chapter 1, I set out three questions that I have tried to hold in mind throughout my research. What is happening at any given time? How can I make sense of this? And what can I learn from this experience?

While reconsidering my initial research questions in preparation for writing this final chapter, I recalled nearly twenty years ago being helped towards a revelatory understanding. It was before I trained as a child psychotherapist and my understanding of psychoanalytic concepts was patchy and superficial. In my post as manager of the local branch of a national voluntary agency I was struggling practically and emotionally to understand and survive what I perceived as an outbreak of fractiousness, teetering on the edge of open

warfare, in the professional network. In this frame of mind I attended a conference, the title of which I no longer remember. My attention was riveted, however, by the key speaker depicting how workers in social care and allied professions, both individually and collectively, may inadvertently mirror the level of disturbance in those with whom they work. Through helping me to make sense of the complex and dysfunctional organisational dynamics in which I was entangled at that time, this 'borrowed' insight enabled me to step back from a counter-productive 'fight-flight' defensive enactment. Systemic theory also makes a contribution to reflection. My first social work team had the privilege of weekly consultations with a systemic psychotherapist who frequently urged us, individually and collectively, to adopt a 'meta-position'. "Systemic thinking is a means by which people can step back and observe their own position in the system... Once in this position... they are able to monitor complex feedback processes" (Campbell *et al.*, 1994, p.20).

My research study is a continuation of this attempt to understand the powerful processes that can operate in professional networks to frustrate and undermine the 'primary task' to which all those working in these networks would, in good faith, subscribe. On reflection, I have serious reservations about whether I would have had the stamina to pursue my research question through the varied vicissitudes previously described had I not had this enduring interest, relating directly to my 'lived experience' as a practitioner. This is one advantage of the practitioner/researcher role. Another advantage is that it has enabled me to undertake practice-near research in my own workplace, using a combination of participant observation and psychoanalytically informed observation. I doubt that a different research design would have afforded me with material of comparable depth (c.f. Geertz, 2000 on 'thick description').

My 'real time' approach has exposed me to the immediacy of experiences as they have unfolded. In drawing on the conceptual framework of psychoanalysis, I have tried to remain aware of the risk that this could become a theoretical straightjacket. I have argued previously that it is possible to combine psychoanalytic theory with an inductive approach, in my case that of 'grounded theory lite'. Rustin (1997, p.108) makes a similar case when he cites Bick's (1986) discovery of the infantile defence of pseudo-independence in response

to a deficit in parental containment as an example of how the method of psychoanalytic infant observation can generate inductive theory. Hollway (2008, p.151) points to a different though related danger, that of blindly defending one's personal and professional value base. She emphasises the importance of the researcher being willing and able to be open:

... to the new experience and using the resources of one's mind as the instrument of learning, as free as possible of the defences against finding out something that could pose a threat to one's self and the beliefs that form a carapace around it.

A grounded theory approach seeks, in the first instance, to identify patterns or themes in and recursively across the data set, using the constant comparative method. Unlike some forms of thematic analysis, grounded theory goes further than the identification of patterns. It attempts to explain these patterns, investing them with meaning. I have found this methodology to fit well with my area of research in that it is conducive to an exploration of how intra-psychic and interpersonal processes come to be re-enacted at the organisational level (c.f. section 2). It is also an approach that lends itself to a small scale, low technology study, carried out by a single researcher. Braun and Clarke (2006, p.86) comment on how the act of writing is an integral part of the analysis. Neither my untidy and unsystematic field-notes, written in longhand and then incorporated into my reflective case studies; nor my lengthy list of potential coding categories and coding schemes, reached by trawling over and over again through my notes, required any research tools more sophisticated than paper, pencil, biro and lap-top computer. Even the focus group interviews were recorded on a rather elderly dicta-phone.

My intention is for my research approach to demonstrate both 'reflection-in-action' (Schon, 1983, p.ix) and reflexivity. I have also attempted to ensure that my approach and my findings are credible and coherent. In my experience, these are qualities that a grounded theory approach encourages

## **2.1 The role of serendipity: difficulties and surprises**

“We would like to think, as researchers, that we are in control of sampling and research design, but matters are often taken out of our hands. This can sometimes work to our ultimate advantage” (Barbour, 2007, p.64). In chapter 3 I discussed some difficulties I encountered in attempting to carry out my initial research design. These setbacks required me to curtail my over ambitious schedule of case studies and individual and focus group interviews. Researchers inevitably have limited control over the research process and this is especially the case in qualitative research that takes a naturalistic, emergent approach. At the time, as previously described, I felt discouraged and frustrated by my repeatedly unsuccessful attempts to gain the necessary authorisations. This, however, proved to have a fortunate aspect because it resulted in my having a much more realistic and manageable data set. With hindsight, I would have found it extremely difficult to describe in any depth, and/or to organise material encompassing six reflective case studies, six individual interviews and three focus groups. A second serendipitous outcome was the requirement it imposed on me to think carefully about possible reasons for the resistance I had met. One partial conclusion at which I have arrived is that I had become caught up in an enactment of some of the defensive dynamics operating in professional networks that are the focus of my research. Coghlan and Brannick (2005, p.61), noting how, “...in their informal lives, organizations are centres of love, hate, envy, jealousy, good and ill will, politics, infighting, cliques, political factions and so on”, exhort the researcher to tune into their own feelings as a member of that organisation. Staying ‘in tune’, however, can be challenging. A third unforeseen but positive outcome of the setbacks I met was that I needed to reflect long and hard in order to be able to process my disappointment, self-doubt and anger sufficiently well to enable me to continue with the research. Reason and Marshall (2001, p.414) note that when both research topic and method selected are influenced by “a bid for personal development” through encountering “the anxiety of old distress” - in my case, feelings of confused and irritated helplessness on encountering over and over again in working life what I perceived to be perverse organisational dynamics:

Unfortunately...the usual response to the re-stimulated anxiety is defensive, so that we project our anxiety out onto the research situation, thus distorting our perspectives in a way similar to the effect of counter-

transference in psychotherapy...All inquirers need to explore how their unaware distress and psychological defences distort their inquiry (Reason and Marshall, 2001, p.414).

Alongside difficult feelings, the research process also engendered others much more positive, such as curiosity, excitement and a sense of satisfaction. I have appreciated, for example, the impetus the has research provided to extensively 'read around' my subject, discovering and re-discovering authors that otherwise I would not have made the time to engage with. I was also surprised by how much more I enjoyed the experience of undertaking the focus group interviews than I anticipated. I was impressed and heartened by the thoughtfulness of participants' responses and at times moved by their passion and compassion in talking about the young people with whom they work. Thirdly, I now have a sense of achievement mixed with surprise that I did not abandon my research project at any one of several points when I had almost completely lost any sense that I would be able to bring it to a conclusion. Kleinman (1991, p.184) takes the view that difficulties should be viewed as not only inevitable, but also as useful aspects of the research process: "Field-workers do not think of feelings as disturbances that impede objectivity and thus should be overridden. Rather, the feelings become resources for understanding the phenomenon under study." There were times when I experienced the fieldwork phase of my research as lonely and isolated, although much less so than comparable feelings evoked for me when I had previously undertaken traditional participant observation. This attenuation in feelings of isolation was in part because I was undertaking the research in my own workplace as a practitioner/researcher, which alleviated my sense of being a voyeuristic observer of other people's internal and external worlds. (I refer to the potential of focus groups and also of practice-near research and specifically the researcher/clinician role when I propose a number of research applications in section 3.)

### **Section 3. In praise of doubt: research implications**

Praised be doubt! I advise you to greet  
cheerfully and with respect the man  
who tests your word like a bad penny (Brecht, 1976)

In calling my third section 'in praise of doubt' I have borrowed from Brecht as a way of capturing the quality of tolerating uncertainty and 'not knowing' that underpins psychoanalytic theory and practice, psychoanalytically informed psychosocial research and the tradition of reflective and reflexive 'practice-near', small-scale, qualitative research to which my own study belongs. Munro (2011, p.6) refers to "...a commonly held belief that the complexity and associated uncertainty of child protection work can be eradicated". I have previously discussed the defensive stratagem, captured by the term "clarity of blindness" (Obholzer, 1993, p.7.), an over-simplification, which is also characteristic of borderline structures and organisations (Cooper and Lousada, 2005, p. 51) (c.f. chapter 6, section 1). One of the RCWs was perhaps alluding to this trait when she was critical of an expert who was 'a know it all' (RCW focus group, April 2013). Schon (1983, p.ix) refers to the capacity for reflection frequently displayed by practitioners and the way in which they may make use of this to manage "...the unique, uncertain, and conflicted situations of practice". To navigate these 'troubled waters', Mason (1993, p.192) champions a stance of "authoritative doubt", similar to Lord Laming's (2003a) call to social workers to adopt an attitude of 'respectful uncertainty' and 'healthy scepticism'.

### **3.1 'Everyone gets stuck': living with vulnerability and daring to fail**

"Ever tried. Ever failed. No matter. Try Again. Fail again. Fail better" (Samuel Beckett, 1983).

For a professional, not having a solution to a problem can provoke feelings of persecutory anxiety, guilt and a sense of inadequacy. This is one reason why recourse to an expert who is expected to 'sort things out' is an attractive option. However, as one of the RCWs in the focus group expressed it, "*Basically, everyone gets stuck...not sure what to do next*" (RCW focus group, April 2013). The work undertaken by professional support networks involves various forms of ongoing risk assessment, which do not lend themselves to answers but rather to probabilities and 'educated guesses' (Parsons and Horne, 2009, p.57). Main (1989, pp.15-16) writes about a nurse who, in relation to her work with patients, felt that "she had failed as a person and that if she had tried harder, or known more, or been more sensitive, the failure would not have occurred". He

also points out that, alongside her sense of failure, was another feeling, that of “a resentful desire to blame somebody else, doctor, colleague or relative, for the failure” (ibid). Feelings of impotence and shame can lead to anger, despair and the need to find a scapegoat on whom to offload one’s own sense of vulnerability. According to Dartington (2010, p.116), “Living with vulnerability means accepting and understanding one’s limitation and yet continuing to live in an area that is unsafe.” This requires a state of mind that is able to tolerate emotional pain, ambivalence and uncertainty. Such a state of mind, approximating to the depressive position, as previously noted, is subject both to internal fluctuations and also to oscillations between it and the paranoid-schizoid position, with their respective depressive and persecutory anxieties. It is, therefore, inevitable that from time to time people take defensive action against unacceptable reality.

### **3.2 The need for defences**

As Main (1989, p.208) points out, “All of us have weak spots, and against intolerably painful encounters it is inevitable that defences are erected: laughter, forgetfulness, aloofness, scotomata, denial and so forth”. The various coping strategies adopted by social care professionals are understandable, even necessary, to shield them from bearing the full brunt of the massive emotional damage already inflicted on the children and adolescents with whom they work. They can mitigate workers’ feelings of distress, impatience, frustration and anger towards their young clients for inflicting on them so much self-doubt and emotional disturbance. Referring to the type of environment in which social care professionals practise, Cooper and Lousada (2005a, pp.54-55) comment “...in this context of considerable complexity, borderline states of mind may even be understood in part as a sensible retreat”. If and when workers are given an opportunity for reflection, these more or less inevitable responses to the anxiety of the social care task, may enable workers to recognise and learn more about what is going on in their relationships with clients and colleagues:

We may regret that anxiety and defence against close encounter with distress is inevitable...but this does not mean that defence must be thoughtless. We can have some choices...We can hope to replace non-

thinking, automatic, rigid procedures of careful encounter and rigid defence by thoughtful, elastic and adaptive deliberate techniques” (Main, 1989, pp.215-6).

Recognising the tipping point at which functional coping responses turn into pathological defences is anything but straightforward. There can, for example, be a fine dividing line between on the one hand stepping back to create a 'thinking space', in this way galvanising the emotional as well as physical energy required to carry out a complex and difficult task, and on the other hand adopting an avoidance technique.

### **3.3 Management and containment**

“Things can go quickly wrong, and teams [and networks] need a protection against these corrosive psychotic anxieties but a protection that is not too rigid, defensive or damaging” Hinshelwood (1998, p.23). Those who work in professional support networks need to have a sense that their practice is grounded in an experience of effective management and emotional containment. Otherwise it is only too easy to feel overwhelmed by difficult feelings including a sense of isolation, abandonment and anxiety that may reach panic proportions. The internal image of the ‘bad’ absent and/or abandoning parental figure, projected by LAC into workers, at times reverberates around professional support networks. The sense of disconnectedness is reinforced by practices such as very short-term interventions, transfers between teams, the extensive use of agency workers and frequent organisational restructuring. A CAMHS clinician referred to the free-floating anxiety in the network: *“It’s not just managing the anxiety within the family and containing that but managing it within the network as well”* (CAMHS focus group, January, 2014).

One way to think about management and containment is to consider the former as providing a type of paternal containment while the latter offers maternal containment. According to this view, effective management would provide, for example, clarity and consistency in respect to task, boundaries, accountability and so forth. Because of the high levels of risk and uncertainty endemic in work

with 'looked after' adolescents, the sense of safety that effective management helps to foster through providing a consistent, reliable setting for the work is indispensable in progressing the 'primary task' of the professional support network. Emotional containment, on the other hand, in addition to providing opportunities for reflection, facilitates creative and innovative forms of practice as well as matrices of collaborative working relationships across systems of care. To provide anything like adequate care it is important to 'provide care for the carers'. This applies to those working in 'the care system' who are tasked with embodying the slippery concept of the 'corporate parent' in the provision of a sometimes equally elusive 'system of care'.

### *Creating time and space to think: the reflective forum*

Foster (1998b, p.93) writes of the "need to find a mental space inside ourselves and a physical space outside ourselves where it is possible to see and to consider what is going on inside us and around us". Carving out, within busy work routines, a 'thinking space', as well as regular protected time for clinical supervision, enable extremely painful feelings and experiences to be processed and understood as communications about the meaning of emotional disturbance. Part of the explanation is probably unrelated to any projections received from clients/patients, deriving instead from the worker's own life experiences, both historic and contemporary.

Participants in both my focus groups referred spontaneously and in very positive terms to a regular multiagency, interdisciplinary meeting convened by the local authority children's services in which I undertook my practitioner research. I have given it the name 'reflective forum'. An RCW described it in these words:

*...this is about an idea where a group of adults can all come together and everyone comes out with an idea. It doesn't always come out with the right idea but it is a useful space to talk about that young person.*

He felt that it had been "a very useful process. It doesn't happen often enough but when it has happened it has worked very well... I found it interesting but it was quite peculiar" (RCW focus group, April 2013). In response to my question about whether people felt it had moved things on, another RCW commented:

*...what I found useful it was very different from any of the other professional meetings that we go to and it was about, you felt like you came out with a solution of moving things forward. And what was useful*

*was that people who were making the decisions were actually listening to those of us who were doing the groundwork...a lot of the time you don't get that level of interaction.*

One of the clinicians spoke at some length about the reflective forum, of which he is a regular member:

*There is this place where referrals come in when they are highly complex and a lot of different services are involved. It involves the referring team coming to present to a sort of panel of people from different areas including health, mental health, social services and education. And that panel sort of acts, reflects on the work that the referring team brings. And its often very interesting because this might be the first time that the whole network is actually sitting together, you know, apart from in a sort of very action oriented type of setting where decisions have to be taken. This is an opportunity to reflect that we are giving them. And then you notice that actually they have got a lot of skills and a lot of ability to actually think together and to work together but somehow the context has never been right for them to be able to manage, to be able to sit together and to think together. It's often been very fragmented. Whereas in the context that we are offering that sort of chance to think then they are coming together in order to present to us. And so, you know, sometimes networks don't quite realise that they have the skills and the power to actually make a difference. They are sort of stuck in their little silos doing their little bits of work but not really connecting up (CAMHS focus group, January 2014).*

I have quoted extensively from this clinician as it affords a powerful example of reflection in and on practice (Schon, 1983), as well as of a professional support network operating as a 'work group' (Bion, 1961).

### **3.4 Keeping the net in good repair: recognising dependency, interdependency and differentiation**

"When the aim of the workers is primarily to rid themselves of an unbearable experience and of responsibility for a difficult person the client may well fall through the net" (Foster, 1998a, p.66). There is a corrupt form of dependency encapsulated by Bion (1961) in the type of basic-assumption mentality,

dominated by a parasitic dependency, that seeks protection from a leader who will 'sort everything out' on their behalf. However, everyone has legitimate dependency needs, the recognition of which is an important aspect of the depressive position. This realisation is expressed well by one of the RCWs, "... *having somebody you could just tap into... That's what we need because obviously we don't have all the answers, you know, but its just having the support but real support*" (RCW focus group, April 2013).

The denial of dependency needs is an aspect of a narcissistic state of mind in which difference is feared and hated. It may lead to a stance of self-sufficiency that militates, at both individual and collective levels, against effective collaboration and cooperation within professional networks as well as against recognition of the value of specialist experience, knowledge and skills. If, on the other hand, interdependency is welcomed, this will enable different individual workers, professions and agencies to contribute from their particular skill sets to the overall task of the professional support network. For example, in order to be effective, the long-term intensive work of a child psychotherapist focussing on a young person's internal world needs to be complemented and supported by the work of colleagues from other disciplines. This is the rationale for multidisciplinary CAMHS teams. Even so, this aim often remains 'work in progress' (Obholzer, 1991). While it is an immensely greater challenge to achieve a similar level of support within much larger and looser professional networks, it can and does take place, as evidenced by one of the RCWs:

*I just wanted to say like with professionals that if they can work tightly together...when we relay something and you know we said like it's a concern or an issue that they are willing to move...she [a nurse] put herself out, she just came to the home and we managed to talk this child into going along to another person. Thank god that we did because it was a multiple of doors that opened...they were organizing this conference and this and this – everything went crazy and that was because the nurse was willing to put herself out and come to the home (RCW focus group, April 2003).*

Munro (2011, p.7) champions a "move from a compliance culture to a learning culture, where they [professionals] have more freedom to use their expertise in assessing need and providing the right help". This aim cannot be realised unless differential expertise is valued. In the context of professional support networks, this will involve, as one CAMHS clinician expressed it, different

categories of workers recognising, in relation to themselves and also to other categories of workers, “*where...we fit in; what’s the sort of added value of our bit of work*” (CAMHS focus group, January 2014).

## **Section 4. Learning from experience to celebrate small changes: practice, policy and research applications**

*Invariably we have high hopes of restoring people from dreadful states back into whole and happy persons. This task may have only limited chances of success...Very small changes for staff may be a great achievement for a patient. Thus a major and painful gap opens between the achievement that members of staff demand of themselves and one that is realistically achievable* (Hinshelwood, 1998, p.20).

In the introduction to this final chapter I quote from Briton on the acceptance of small, significant changes. Some young people, Dermot for example, are more able to make use of what is on offer than others who, like Kerie, find it terribly difficult. There is a need, both individually and as a professional support network, for workers to be realistic rather than omnipotent about what is feasible and to accept, even celebrate, small improvements. It is important to be aware of both the potential and the limitations of any specific role within the network and to bear in mind the inevitability from time to time of ‘failing’ the young person and being perceived by her or him as doing so. It is equally important for the young person to experience the worker recovering because this will help the former to internalise a similar hopeful capacity. Armstrong (2005, p.106) argues that the ubiquity of the processes through which painful emotions that are generated in work with young people may be displaced onto colleagues where they rigidify would indicate “not so much to the need for fundamental structural change as for an alertness and ability to process and scan one’s experience...to discern its meaning”. This capacity relates closely to that of being able to learn from experience (Bion, 1962a). My recommendations for practice, policy and research stem directly from my research findings. While I am by no means the first to articulate them, they are worth reiterating because, although deceptively simple, they have proved extremely difficult to embed in their respective domains.

## **4.1 The practice domain**

Reflective professional practice draws on the clinician's or practitioner's experience and skills base, combined with an awareness and acceptance of the importance of 'negative capability', in steering through anxiety-provoking practice situations, often involving risk assessments. When overwhelmed by their work they find it difficult to perceive or think about what they are encountering. Exhaustion may result in emotional withdrawal or professional and organisational 'turf warfare'. I offer five broad, interrelated practice recommendations, each of which contributes towards challenging and dismantling dysfunctional professional and organisational defences. They cover the following aspects of practice:

### **Communication**

*I think good communication verbally, via email and I think working with external professionals who have compassion... I think having a social worker who understands children and understands the needs of children because not all social workers do, and one who is open to learning and to listening because sometimes you can sit back and you can see the relationship between yourself and external professionals growing and developing in a really healthy way. And as service providers our views and thoughts are respected and valued and so forth. I think that, for me anyway, those are the key things but above all communication. Nothing outweighs communication for me (RCW focus group, April 2013).*

This quote demonstrates how the values underpinning social care including: compassion, empathy, respect and receptivity also facilitate communication. There is an urgent need to continue developing responsive communication channels within and across complex professional support networks that encompass different agencies and professions. These should incorporate timely feedback mechanisms and to accommodate the increasing speed of the contemporary proliferation of networked ways of working. The effective flow of communication will help to counter endemic tendencies to adopt polarised positions and/or to fragment, that derive partially from the split projections of disturbed service users. Only then can the care system effectively function as what Foster (1998b, p.92) refers to as 'a system of care'.

### **Continuity**

*I think some of the advantages as regards to the clinician remaining*

*involved after they have done their initial assessment is that it offers the network and the family consistency...another issue is that some of these networks do change especially when a child is transitioning through the services... And I think it sometimes stops the fragmenting of the network...* (CAMHS focus group, January 2014).

A sense of shared history and continuity in relationships both between workers and service users and also between colleagues, together with some consistency of setting, encourages the establishment and maintenance of positive alliances based on mutual trust. In a work context of uncertainty and risk this development is critical. Batmanghelidjh (2013c, p.7) describes how “with these types of severely damaged children, you’ve really got to hang in there. You have to be relentless in your care and be prepared to go backwards and forwards”. A sense of containment is a necessary precondition for accessing ‘thinking spaces’ in what is often a frantically action oriented organisational environment. One type of thinking space can be provided by a specialist mental health report if and when used as a working document that is part of a process rather than as an end in itself. A CAMHS clinician spoke of “*keeping that report alive and keeping it working so that everyone is working together for the young person*” (CAMHS focus group, January 2014). As well as requiring emotional stamina, another core value in social care, this needs sufficient time to establish and maintain relationships, an elusive commodity in contemporary resource depleted professional networks. A central weakness of many ‘expert’ reports is that once the report is written the expert withdraws and is therefore unavailable as a reflective and reflexive resource to the support network in the ongoing process of care planning. An RCW expressed his near panic in the face of perceived ‘abandonment’ by the report writer:

*...if the document is just dropped and left we are left again, like ‘Oh no, what are we going to do?’ A report was done there. How are we going to help them? Whereas if the person was still there, when they [the young service user] are doing the risky things and the risk is escalating he would be aware of, or she would be aware of the same. I think it would be perfect, it would just be perfect if it could happen* (RCW focus group, April 2013).

As Menzies Lyth (1989b, p.33) points out, “This feature is notable in psychoanalytically orientated consultants and others whose work has been influenced by them. They stay around.”

### Creating a team around the 'looked after' adolescent

The existence of such a virtual team would facilitate both communication and continuity. It is also the case that for young people in the care system, most of whom do not for a number of reasons access individual psychotherapy, the transference is more likely to be to the professional support network acting as the corporate parent than to a particular individual. This is extremely challenging, the more so the bigger and more diffuse the network. It follows that it would be helpful if the latter can agree to identify a small number of key professionals who would be supported by all those in the larger network. The key professionals would offer emotional containment to the young person, and also to each other, taking in and detoxifying extremely painful projections and managing destructive and self-destructive enactments. Within this small team, one worker, normally the adolescent's allocated social worker, would be designated not as the 'team leader' in a hierarchical sense since team membership would be drawn from different agencies and professions, but rather as the 'key professional', at the heart of emotional and practical communication flows, both within the virtual team and between it and the wider network: *"I think it would be useful if we could have just one person as opposed to a selection of people...if we just had one key person that we could link into"* (RCW focus group, April 2013).

### Clinical supervision

The availability of regular clinical supervision, whether individual or group, in addition to essential line management supervision, affords an opportunity for professionals in the support network to recognise and articulate the impact on them of their clients/patients. Central to this is the barrage of uncomfortable, unwanted and difficult feelings generated by the work and the temptation to 'take cover' though adopting various counter-productive defensive stratagems. Main (1989, p.19) describes how the nurses in the clinical supervision group he ran:

...had owned painful distresses, concealed ailments connected with certain patients' ailments, and, by disclosing these in respect of themselves and each other, they arrived not only at an increased capacity to recognize insincerities in their daily work, but at personal easement in it. They became less afraid of difficult situations and surer at their craft.

Across 'cash strapped' CAMHS and even more so in social care there is a dearth of appropriate consultation and clinical supervision, both individual and group. Psychoanalytic child psychotherapists are potentially well placed to offer this service, subject to Shuttleworth's (1999, p.31) caveat about the "...separate territories of the public sector and psychoanalysis, with their vastly different languages and customs". My use of empirical rather than psychoanalytic concepts to construct a theoretical framework enables child and adolescent psychotherapists, skilled in working with transference and counter-transference feelings, to describe these processes in language that allows colleagues who are not psychoanalytically trained to recognise, process and make effective use of them as tools for understanding and communication in their relationships with both service users and colleagues. My research affords an extended example of both the intensity of difficult, unwanted emotions stirred up for those working with distressed and disturbed service users and also the value of having protected and facilitated time to reflect on these. A significant benefit of deploying the thinking my research has generated is that, through facilitating the transformation of Bion's 'nameless dread' (1962b) into realistic and manageable anxiety, psychoanalytically informed clinical supervision has the potential to foster in a wide range of social care and mental health workers an approach to their practice that is relationship-based and encourages/supports curiosity, self-discovery, learning from experience and a capacity to tolerate 'not knowing'.

### *Flexibility and creativity*

Munro (2011, p.8) criticises the contemporary prescriptive organisational culture in social care for stymieing "the profession's ability for developing its own knowledge and skills". When innovation and creativity are discouraged, the potential for professionals to learn from experience is also inhibited. An RCW praised the flexible way in which a mental health assessment was carried out and also identified two complementary gains, fostering communication and continuity within the network, stemming from this flexibility:

*What we found useful, what we did recently with one of our children who wouldn't meet with the clinician, after the report had been written they met with the key worker and the social worker and we had regular meetings and that was useful to look at how the child, how we could all continue to best support the child and address situations as they arose...even though the child refuses to meet we will meet and that's positive... And I think it*

*helps to strengthen the professional network as well in terms of how we were communicating with each other and I think, as [name of colleague] says, it gives a different insight into the child because we always have to remember it's a very sterile environment when the child meets with somebody because they think the clinician is going to think 'Oh, I'm mad' (RCW focus group, April 2013).*

Shuttleworth (1999, p.30) argues that, “new clinical pathways have to be found – pathways that remain psychoanalytic and yet are viable in a setting that does not have psychoanalysis at its centre”. Other writers echo his exhortation to be flexible and innovative in seeking out ways to extend the potential applications of psychoanalytic theory in CAMHS beyond the traditional remit of child and adolescent psychotherapists, i.e. to undertake long-term, sometimes intensive, individual psychotherapy, supplemented by group-work and clinical supervision when requested. There has been a proliferation of specialist psychotherapy posts working exclusively with LAC, often in the same team as local authority social workers. These tend to encompass consultations to the support networks; clinical supervision; work with substitute parents; and outreach work in addition to direct work with LAC. The challenge is to retain what Shuttleworth (1999) refers to as ‘dual citizenship’:

Sometimes it feels that we are pressed to be anything and everything other than what we are. While an understanding of other modalities is essential for the child psychotherapist, the core of what we convey in our specialism must neither be lost, nor should we apologise for it. It is what we bring and what we do well (Horne, 2009, p.111).

## **4.2 The policy domain**

“There is no formula or government policy that is going to eliminate either risk or mental disorder, although some debates would suggest that this might be possible...” (Foster, 1998b, p.85). I suggest that the notion of ‘one size fits all’ grandiose policy formulations is a form of magical thinking. Organisational life, like every other aspect, is complex, messy and uncertain. ‘Stuff happens’ all the time, upsetting predictions and prescriptions. This in no way disqualifies the aim of trying to identify patterns, rhythms and underlying meanings in and through lived experience. It does, however, question the positivist ambition to discover one or a small number of universally applicable ‘correct’ ways to manage, in the sense of controlling, the organisational environment. I advocate for a more

modest approach, one that encounters specific 'local' difficulties with an open and enquiring mind and draws on past experience to help make sense of that which appears to be novel and problematic.

A contemporary example of an issue that was probably initially considered by those involved as a local and restricted problem but which has subsequently been revealed to have much wider relevance, generating increasing public concern and anger, is the recent revelation of widespread child sexual exploitation (CSE) in Rotherham (Jay, 2014). As do my own research cases, although on a much heightened level, the Rotherham case both demonstrates and challenges the dysfunctional nature of the prevalent 'blame culture' in health, social care and education. It is likely that, as child psychotherapists increasingly work in multidisciplinary, interagency environments, they/we will also find ourselves the targets of scapegoating and public opprobrium. My findings contribute towards an understanding of the genesis of malign dynamics in scenarios where there are very few 'rotten apples' but many systemic failures that can create the conditions leading to individual and sectoral demonisation. Through incorporating an examination of professional and organisational, alongside intra-psychic and interpersonal, defences, my research findings provide the framework for a holistic analysis of pathology and breakdown that can help to inform safeguarding policies.

A key related issue emerging from the recent CSE revelations in Rotherham, Oxford, Telford, Bristol and other communities across the U.K. has been the apparent inability of senior officers and local and national political leaders to accept responsibility and accountability and to 'learn from experience'. Professor Alexis Jay, in her report on CSE in Rotherham (2014, p.1) comments "...the collective failures of political and officer leadership were blatant. From the beginning, there was growing evidence that child sexual exploitation was a serious problem in Rotherham." However, although - or perhaps in part because - knowledge of the abuse was widely shared, there was a tendency to assume that someone else would step in to stop it. An issue or problem that belongs to everyone is, too often, owned by no one. In the Rochester case, Jay's report was the seventeenth over sixteen years. The degree to which inconvenient, if not unbearable, reality was avoided could be said to amount to the legal term

'willful blindness' (Analysis, 2014). The defence of 'turning a blind eye' and related 'culture of disbelief' were endemic among senior council officers and local police. No one wanted to believe The Times investigative journalist, Andrew Norfolk, who had reported on what was happening two years earlier. There was not only a tendency to 'blame the victim', i.e. the young adolescent girls who were sexually exploited, but also to 'shoot the messenger', for example, a Home Office researcher seconded to Rotherham was dismissed and the information about the organised sexual and physical child abuse contained in her report was suppressed by the council (Today, 2014).

The revelation of these faults of both omission and of commission raises questions relating to where leadership comes from, the forms it should take, and how it can be fostered. there have been calls to promote 'leaders in training', 'everyday heroes' and 'courageous leadership' through finding ways to enable and encourage people to 'speak truth to power', even when intimidated by bullying professional and/or organisational and/or political cultures (Analysis, 2014). My research findings demonstrate how endemic anxiety can disable effective leadership and collaboration, instead encouraging workers and other stakeholders to evade both individual and shared responsibility through a range of unconscious defensive strategies. They also reveal the ways in which raw feelings can be very misleading and in need of examination as potential sources of information, rather than being considered unreflectively to be 'the truth'. Almost certainly senior professionals and politicians caught up in the Rotherham case felt at the time that their unresponsiveness was justified.

#### **4.3 The research domain**

I would like to argue that small-scale, practice-near qualitative research offers a viable way for practitioners to reflect in some detail on their own practice and the organisational dynamics operating in their work settings. I am attracted to Schon's (1983, 1987) notion of an interweaving of practice and research in the course of a working life. It could be envisaged as a very slow motion adaptation of both Lewin's concept of AR (1946) and also Kolb's (1998) depiction of the experiential learning cycle, taking place recursively throughout one's career.

Ideas are generated by practice experience and tested through very small-scale research studies which complement rather than disrupt working life. While acknowledging an element of romance in this presentation, I believe it is achievable and would potentially enhance both practice and research.

My research was prompted by a wish to allow - perhaps even oblige - myself to take sufficient time to reflect in some detail about processes, encountered over and over again in a varied professional career, which have intrigued, frustrated, confused and at times confounded me. My aim has been to remain engaged in practice while providing myself with a 'reflective space' for that practice. My motivation was heuristic in that I wanted to learn something for and about myself and to test my capacity to remain open to what I might find out. The methodology I chose was also heuristic to the extent that the constant comparative method of grounded theory is reliant on trial and error. It is complementary to the 'hands on', practice-near approach to research that, as a researcher/clinician, I chose to adopt. I number myself among those described by Schon (1983, p.43) who "...when asked to describe their methods of enquiry ...speak of experience, trial and error, intuition, and muddling through." I believe that I have gained significantly, both professionally and personally, by applying the ways of thinking developed through my research study to an in depth exploration of a professional context that I thought I knew well, but which I learned was much more multi-layered, complex, at times almost impenetrable, than I had previously realised. I have also been encouraged by the validation of types of knowledge that emerge from experience (Greenwood and Lowenthal, 2005) and, as does Polanyi's notion of 'personal knowledge', recognise the "...fusion of the personal and the objective" (Polanyi, 1974, p.214).

In my experience, the methodology of thematic analysis, including a grounded theory approach, fits well with the type of small-scale qualitative research projects that I envisage being undertaken by researcher/clinicians in that they facilitate the identification of themes and concepts in the data that, once linked up and theorized, have the potential to generate further research questions (Burck, 2005, p.257). I suggest a number of areas as potential examples of small-scale practitioner/researcher studies that relate broadly to some of my

research findings, have intrinsic interest and are amenable to an approach similar to that of my own study:

- Research into local models of good practice similar to the 'reflective forum' (section 3);
- Ethnographic research exploring the concept of 'clarity of blindness' in relation to middle and senior management (I envisage potential difficulties in obtaining authorisation);
- Action research in collaboration with young people, recruited through organisations such as Voice of the Child in Care and Young Carers' groups, on subjects identified by them and drawn from their life experiences;
- Research utilising focus groups with young people. Subjects might include, for example, their experiences of and feelings about moving into 'semi-independent living' at the age of sixteen;
- Focus groups with foster carers. Parsons and Horne (2009, p.56) identify how, rather like the perceived marginalisation of the RCWs in my focus group, foster carers are often ignored in professional support networks: "As a consequence many feel unsupported and denigrated, a split is engendered that becomes polarised and cannot be addressed."

I have enjoyed the experience of conducting my two focus groups much more than I had anticipated and now recognise the potential of the focus group as a participatory research technique:

Inviting participants to unpick their perceptions and experiences can allow them to share this work, by harnessing their insights and commentaries as they engage in generating data. Perhaps, indeed, it is the researcher who is being empowered - or, at the very least, being given a helping hand by respondents (Barbour, 2007, p. 37).

I would also welcome the opportunity to participate in a research group comprising practitioners similar to that facilitated by Main (1989, p.16-17). Referring to "the potency of group discussion as an instrument of research into relationships with patients", he argues "only a group could achieve the capacity to recall past events with the merciless honesty for detail and corrections of evasions and distortions that this one required from and tolerated in its members".

## **Section 5. My research contribution to the discipline of psychoanalytic child psychotherapy**

### **5.1 Originality**

*“It is not possible to be original except on a basis of tradition”* (Winnicott, 1980, p. 117, italics in original).

Winnicott (1980, p.117) posits an“...interplay between originality and the acceptance of tradition as the basis for inventiveness.” As others, including Jaques (1955) and Menzies (1960), have done before me, I employ traditional psychoanalytic concepts, including projection and transference, and also psychoanalytic methodology, most notably the use of counter-transference, to explore complex psychosocial practice environments. In so doing, my findings contribute to the expansion of child psychotherapy research beyond the clinical relationship and are innovative in their application to multidisciplinary, interagency networks. The hurdles facing contemporary complex safeguarding services, encompassing CAMHS and education as well as social care, are more ubiquitous than most people want to believe or can bear to acknowledge. Within this challenging research environment, I identify powerful unconscious dynamics being played out at intra-psychic, interpersonal *and* organisational levels. I demonstrate the pervasive, frequently pernicious nature of such processes and how difficult they can be to detect because of their largely ‘taken for granted’ nature. My exploration of this terrain affords potentially creative insights to clinicians and other practitioners working in increasingly intricate contemporary professional networks.

While drawing substantially on psychoanalytic theory and the methodology of grounded theory, I attempt to be inventive, both in employing a number of systemic concepts and also through borrowing from psychology and ethnography. By so doing, I am able to extend the depth and potential scope of my research findings and also to offer an example to other practice-near researchers and researcher/clinicians in being imaginative, perhaps even playful, in their adoption and adaption of both theory and methodology to explore specific research questions of particular relevance and interest to them.

## **5.2 Accessibility**

My research findings are framed in language that is fresh and accessible to those who have not had a psychoanalytic training. The three groupings of core categories, or themes, which emerged from trawling my dataset and which relate respectively to: the environments (external worlds); feelings (internal worlds); and defensive responses of both LAC and their workers, are empirical, rather than psychoanalytic, concepts, although for the most part translatable into psychoanalytic theory (Anderson, 2006). I deliberately use 'everyday language' to describe my themes and sub-themes, for example 'a very short fuse', 'taking cover', 'shell shocked' and 'passing the parcel', in order to give them vividness and immediacy. They demonstrate, *inter alia*, how 'common sense' responses to increasing individual and/or organisational pressures, such as a reliance on following procedures, may have little impact on or even undermine good practice. My aim is to enhance the capacity of professionals, both individually and in the group context, to recognise and consequently be able to reflect on 'ordinary', unremarkable and for the most part unremarked, toxic processes. In working towards this goal I have tried as far as possible to avoid psychoanalytic terminology lest it is inadvertently confusing and/or misleading to those not psychoanalytically trained. As Hollway and Jefferson (2013, p.158) point out:

The terms transference and countertransference can create a mystique around some fairly basic ideas about the flow ('transfer') of unconscious dynamics between people and in groups, and this is partly because of how it slips between the clinical frame and the understanding of everyday dynamics.

## **5.3 Positioning child psychotherapy**

In the multidisciplinary professional 'tower of Babel', described by Shuttleworth (1999) where the high monetary price of expertise is increasingly being questioned in terms of cost effectiveness, psychoanalytic child psychotherapy needs to evidence the value of both the direct clinical services it provides, namely: highly skilled assessments, individual and group psychotherapy, work with parents and carers and joint work with professionals from other disciplines; and also to demonstrate the range and flexibility of its overall remit, which includes outreach, teaching, consultation and clinical supervision. It is perhaps

in relation to clinical supervision that Bion's model of container/contained (1962a) is most apparent in its provision of an essential holding environment for the supervisee to articulate, explore and learn from painful feelings that threaten temporarily to overwhelm her/his capacity to think. However, the potential application of this powerful conceptual tool is not limited to supervision and direct clinical work. It enables child psychotherapists, primarily trained and experienced in working within clinical settings, to extend and apply their/our psychoanalytic expertise to psychosocial contexts. The resulting enhanced understanding of the volatile work cultures that operate within a context of 'environmental overload' not only facilitates the survival and growth of child psychotherapy as a profession but also, through sharing these insights with a range of colleagues, provides a valuable source of containment to counteract tendencies towards organisational and professional fracturing and fractiousness that emerge in turbulent times. On a more positive note, the 'joined-up' thinking informing my research underlines how the conceptual framework familiar to psychoanalytic psychotherapists has the potential to enhance collaborative working practices both within CAMHS and also across mental health and social care.

#### **5.4 The value of a research stance in child psychotherapy**

At the risk of repeating points made previously, I want to emphasise the value of research to psychoanalytic child psychotherapy, especially but not exclusively in relation to its potential capacity to expand the body of theories and concepts available to the profession. As noted above, my approach to my own research was influenced by Schon (1983, 1987) who advocates an interweaving of research with practice throughout one's career in order to enable ideas derived from lived experience at work to be interrogated and explored within the formal discipline of selected conceptual and methodological frameworks. The largely inductive method of grounded theory fits well with the modest, practice-near research projects that I envisage being undertaken by researcher/clinicians. Core categories or themes, together with their patterned interrelationships, are identified and evidenced as emerging from the data. When theorised and located within conceptual frameworks, these concepts and theories can enrich

the evolving canon of psychoanalytic theories and psychoanalytically informed empirical concepts. Such small-scale, qualitative research projects, accessible and relevant to those who want to continue in practice rather than becoming full-time researchers, can contribute accumulatively to the theoretical base of the profession. “The meaning uncovered in psychoanalytic research will be linked to underlying structures, which may have a wider significance than the specific context of the research cases” (Anderson, 2006, p. 333).

Another consequence of a marriage between research and practice would be an expansion in depth, scope and relevance of the contribution that psychoanalytic child and adolescent psychotherapy could make to both clinical practice and, perhaps even more significantly, to the increasing range of indirect work the discipline is invited/expected to undertake. There exist puzzling un/under-researched questions and areas of practice that, while generally acknowledged, are not explored in their particularities. An important interrelated benefit would be the growth in the evidential base of the profession. In the current deteriorating socio-economic and political climate confronting both service users and clinician there is an urgent need to become ‘smarter’, more knowledgeable about our practice, including being able to demonstrate it’s evidence-base. There is a need for practice-near research that enhances, as well as identifies, good practice and understands the pressures on practitioners to perform sub-optimally. Such research would incorporate detailed, accurate and authentic accounts of practice and articulate the extreme emotional as well as practical pressures on those who work in contemporary professional formations.

A further desirable outcome of a widespread positive research orientation would be to debunk the idea that research is restricted either to a highly specialist activity or to a rite de passage for the trainee, marking entry into the profession. Instead, it would encourage clinicians to view research as an intrinsic aspect of the developing identity of any child psychotherapist. The characterisation of practice-near research as continuous professional development would encourage clinicians to explore areas of direct interest, significance and concern and potentially generate empirical and psychoanalytic concepts and theoretical frameworks. Meanwhile, small-scale qualitative research studies of

the type that I have conducted afford valuable opportunities for clinicians to reflect in some detail on their own practice as well as the interpersonal and organisational dynamics operating in their work settings.

Many clinicians are wary of research because it is perceived as an isolated and isolating activity. My own experience and that of others with whom I have spoken tends to support this view. The researcher, however, does not need to cut herself off, indeed there are persuasive arguments for the inadvisability of so doing. "The cultivation of a research stance based on openness is complex and psychologically challenging, both at the level of theory and research practice. It can be aided by the support of others" (Hollway and Jefferson, 2013, pp.154-155). And again "...emotional experience (in research encounters) requires reflection; for which time, containment, and the support of others is valuable" (ibid, p. 166). Kleinman (2002, p. 376), in proposing "... a model of scholarship as a joint venture...", takes the argument even further "Your work wasn't done until it was out there for others to read and use. That was a moral obligation; you were part of a community where people learned from each other and you should participate" (ibid, p.376). Research has, therefore, the potential to be pro-social, and to exercise a centripetal force within the discipline of child psychotherapy. According to Glaser and Strauss (1967, p.11) "The great theorists... have given us models and guidelines for generating theory... many of us can follow in their paths...". It does not take a "Genius" to generate a useful grounded theory. I propose a working model of practice-near, small-scale qualitative research studies, undertaken occasionally almost as a matter of course, preferably as part of a research team created for example from a professional interest group or ongoing seminar. If such a model were widely adopted, it would embed a research stance into the child psychotherapy profession, thereby facilitating the expansion of the conceptual and theoretical repertoire at its disposal, both psychoanalytical and empirical.

## Summary. 'Not drowning but waving'?

I was much too far out all my life  
And not waving but drowning.

These two final lines from a poem by Stevie Smith (1957) have echoed through my working life. I have asked myself on many occasions whether I was waving or drowning. Cooper and Dartington (2004, pp.143-144) argue that key concepts derived from systems psychodynamic thinking, including: the container/contained model; the distinction between task and anti-task activities; and the closely related 'work group' and 'basic-assumption group' mentalities; are of limited use in understanding the dynamics of contemporary, loosely boundaried, organisational formations. They propose that we may be on the threshold of a genuine paradigm shift into that of the network which, rather than just being a variant of a complex open system, can potentially help make sense of genuinely new organisational forms. While I readily admit to having insufficient understanding of this area to formulate a coherent opinion either way, their view may help to account for the reluctance, bordering on panic, that I and many of my colleagues feel as we are precipitously catapulted into unfamiliar organisational environments. This entails a concomitant need to adjust rapidly to the novel working conditions and cultures they generate. In the meantime, I continue to find meaningful the concept of containment and the idea that there are many ways in which professionals may become defensively uncoupled from the 'primary task' of the professional support network. The title of my thesis, 'don't shoot the messenger' alludes to the emotional difficulties experienced by workers confronted with the painful external and internal worlds of young people in the care system and their understandable reluctance to engage with the primary task, evocatively described by Obholzer (1991, p.3):

Viewed from the perspective of society and its institutions, mental health [and social care] institutions are one of society's several receptacles to take in, and hopefully deal with, distress and psychic and social pain that cannot be dealt with by society's ordinary institutions, for example family and social networks, social and educational services, community health services, etcetera.

The overall aim of my research study has been to trace emotional disturbance in young people in crisis and in those who work with them; and also to identify the defensive barriers erected to ward off this unwelcome 'fact of life'. I have

sought to demonstrate the dynamics involved in the suffusion and transmission of emotional pain among and between young people and their workers. I have also offered evidence to support my argument that individually derived defensive responses can become rigidly entrenched at an organisational level, from where they exert massive influence on individuals to conform to pathological organisational cultures. However, rather than being flooded by and drowning in this torrent of anxiety, I choose to ally instead with Raymond Williams in believing that, "To be truly radical is to make hope possible, rather than despair convincing" (Williams, 1989, p. 118).

## Appendix. University Research Ethics Committee approval letter



Professor B Harrison  
SHSS  
Docklands

ETH/13/20

01 September 2010

Dear Professor Harrison,

Application to the Research Ethics Committee: Don't shoot the messenger! An exploration of how professional networks struggle to receive contain and process painful communications from and about adolescents in the care system (P Langton)

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

Debbie Dada  
Admissions and Ethics Officer  
Direct Line: 0208 223 2976  
Email: d.dada@uel.ac.uk

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Research Ethics Committee: ETH/13/20

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: 10/9/10

Please Print Name: PROF BARBARA HARRISON

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