PLACEMENT BREAKDOWN IN FOSTER CARE WITH CHILDREN UNDER-FIVE: A PSYCHOANALYTIC VIEW OF THE CAREGIVING RELATIONSHIP UNDER STRESS

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Abstract

This study explores the interactional processes between a foster carer and a child, aged under-five, who has experienced early abuse and neglect. Data was gathered from semi-structured interviews with six foster carers, who had ultimately agreed for the child to be removed from their care. The data was analysed using Interpretative Phenomenological Analysis. The proposal is that an understanding of psychoanalytic concepts can bring insight to situations which were felt to be unbearable and beyond understanding. The study suggests that knowledge about external reasons for placement breakdown is not enough without a focus on internal factors, and shows how a psychoanalytic perspective can elucidate the processes occurring between child, carer and their family, and the wider system. The focus is on the meaning of behaviour, rather than just descriptions of it, and the impact of the emotional experience of looking after the children. The need for a reflective space and the use of reflective practice is emphasised, as is training for all concerned.

Declaration

This thesis represents my own research and original work. It cannot be attributed to any other person or persons.

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TABLE OF CONTENTS

Chapter 1 Introduction 7

Chapter 2 Literature Review 11
2.1 Introduction 11
2.1.1 Children and families in Scotland 12
2.1.2 Looked After children in Scotland 13
2.1.3 Mental health of Looked After children 14
2.1.4 Foster care recruitment 15
2.1.5 Foster care in Glasgow 15
2.1.6 Choosing to become a foster carer 16
2.2 **The caregiving relationship** 16
2.2.1 Introduction 16
2.2.2 Foster care 17
2.2.3 Short-term foster care 18
2.2.4 Permanence 19
2.2.5 Placement stability and breakdown 19
2.2.6 Support for carers 22
2.2.7 Birth family 23
2.3 **Neglect and abuse** 23
2.3.1 Perpetuation of deprivation 24
2.4 **Trauma** 26
2.5 **Neurobiology and the developing brain** 27
2.6 **Attachment** 30
2.6.1 Disorganised attachment 31
2.6.2 Disorganised caregiving 32
2.6.3 Internal working models 33
2.7 **Reflective Functioning** 34
2.7.1 Parental reflective functioning 35
2.8 **Psychoanalysis** 35
2.8.1 Containment 35
2.8.2 Splitting 37
2.8.3 Projective identification 38
2.8.4 Transference and countertransference 40
2.8.5 Emotional availability 41
2.8.6 Ghosts in the nursery 42
2.9 **Emotional Impact of Caring for Children** 44
2.10 **Institutional Dynamics** 45
2.11 **Reflections on Literature Review** 46

Chapter 3 Research Methods 50
3.1 **Qualitative research** 50
3.1.1 Qualitative research and child psychotherapy 50
3.1.2 Subjectivity and reflexivity 51

3.2 **Interpretative phenomenological analysis** 52
3.3 **Data collection** 54
3.3.1 Recruitment 54
3.3.2 Sample size 55
3.3.3 Variables 55
3.3.4 Recording of data 55
3.3.5 The setting 56
3.4 **Sources of data** 56
3.4.1 Interviews with Carers 56
3.4.2 Interviews with Social Workers 56
3.4.3 Interviews with Supervising Social Workers 56
3.4.4 Semi-structured interviews 57
3.4.5 Other sources of data 57
3.5 **Presentation of data** 58
3.6 **Data analysis** 58
3.7 **Research Ethics** 59
3.7.1 Formal ethical approval 59
3.7.2 Consent 60
3.7.3 Anonymity 61
3.8 **Reflections on methodology** 61
3.8.1 Advantages of IPA 62
3.8.2 Limitations of IPA 63

Chapter 4 Findings 64
4.1 Introduction 64
4.2 **Case One: Alistair** 67
4.2.1 Social Worker interview 69
4.2.2 Carer interview 72
4.2.3 Process of the interview 78
4.2.4 Supervising Social Worker interview 83
4.2.5 Support 85
4.2.6 Reflections 85
4.3 **Case Two: Mohammed** 88
4.3.1 Social Worker interview 90
4.3.2 Carer interview 92
4.3.3 Process of the interview 99
4.3.4 Supervising Social Worker interview 100
4.3.5 Support 101
4.3.6 Reflections 102
4.4 **Case Three: Gemma** 105
4.4.1 Social Worker interview 107
4.4.2 Carer interview 109
4.4.3 Process of the interview 118
4.4.4 Supervising Social Worker interview 118
4.4.5 Support 119
4.4.6 Reflections 120

4.5 **Case Four: Jess** 123
4.5.1 Social Worker interview 125
4.5.2 Carer interview 127
4.5.3 Process of the interview 136
4.5.4 Supervising Social Worker interview 138
4.5.5 Support 140
4.5.6 Reflections 141
4.6 **Case Five: Chelsea** 144
4.6.1 Social Worker interview 146
4.6.2 Carer interview 151
4.6.3 Process of the interview 158
4.6.4 Supervising Social Worker interview 159
4.6.5 Support 163
4.6.6 Reflections 164
4.7 **Case Six: Jack** 167
4.7.1 Social Worker interview 169
4.7.2 Carer interview 172
4.7.3 Process of the interview 178
4.7.4 Supervising Social Worker interview 180
4.7.5 Support 184
4.7.6 Reflections 184

Chapter 5 Discussion 187
5.1 Introduction 187
5.2 External factors 188
5.3 Emotional impact 192
5.4 Paranoid-schizoid functioning 194
5.5 Avoidance of emotional impact 200
5.6 Emotional availability and reverie 203
5.7 Process of the interviews 205
5.8 System issues 209
5.9 Need for a reflective space 218
5.10 Aftermath 221
5.11 Risk and protective factors in placement breakdown 222

Chapter 6 Conclusion and Recommendations 224
6.1 Conclusion 224
6.2 Reflections on methodology 225
6.3 Recommendations 227
6.3.1 Practice 227
6.3.2 Policy 229
6.3.3 Research 230

Bibliography 231

Appendices

Appendix 1 - Information Sheets 247
Appendix 2 - Consent Forms 253
Appendix 3 - Interview Schedules 255
Appendix 4 - Emergent themes (IPA) 262
Appendix 5 - Super-ordinate themes (IPA) 270

Tables

1. Length of interviews and word count 65
2. Living with conflicting feelings 78
3. Information known 189
4. Main concerns 216
5. Risk and protective factors in placement breakdown 223

Figures

1. External factors 188
2. Paranoid-schizoid functioning 195
3. Avoidance of emotional impact 200
4. Process of the interviews 206
5. System issues 210

Boxes

1. Alistair 67
2. Mohammed 88
3. Gemma 105
4.1 Jess 123
4.2 Emotional impact 133
5 Chelsea 144
6 Jack 167

Abbreviations

CP - Child Protection
DVR - Digital Voice Recorder
IPA - Interpretative Phenomenological Analysis
SW - Social Worker
SSW - Supervising Social Worker

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Dedicated to my mother, who died as I was completing final revisions.

1. INTRODUCTION

The idea for this research project arose from my experience of working with foster carers[1] and children placed with them who have experienced neglect and abuse, specifically when this relationship has become so intolerable for carers that they felt they had to end the placement.

My thoughts and interest arose from my work as a Child Psychotherapist in a specialist Child and Adolescent Mental Health Service (CAMHS) team for Looked After and Accommodated Children (LAAC) in Scotland. The team was created to address the issue of those children not receiving a mental health service due to frequent moves of placement. The children who are referred to the team have experienced extreme neglect and abuse, with a history of placement breakdown[2] and disturbing and distressing behaviour. The team consists of a Consultant Psychiatrist, Consultant Psychologist, Clinical Psychologist, a Clinical Nurse Specialist, two Nurse Therapists, and a Child Psychotherapist. We also have a Trainee Child Psychotherapist and, at various times, a Trainee Psychologist.

Much of the work of the team involves working systemically with the network around the child, but we also offer psychotherapy to individual children and work closely with carers. We often meet carers who are on the point of giving up, or the child is referred at the point of breakdown when it is too late. Over eight years of working in the team, as a Trainee and subsequently a qualified Child Psychotherapist, I have developed some expertise in working with carers and, more recently, with child and carer together.

I became interested in placement breakdown, which often occurs in a sudden and dramatic way, while working with experienced carers who were looking after two

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[1] Henceforth, for economy of expression only, I use the word 'carer' to denote foster carer, using 'she' to refer to a carer and 'he' to refer to a child.

[2] Although the fostering agency uses the word 'disruption', I have chosen to use the word 'breakdown'. 'Disruption' implies a pause, as though things will be resumed, while 'breakdown' implies something more final. For this study, 'breakdown' means a child being moved from placement at the carer's request and not being returned.

siblings, age three and five, both of whom the carers had declared they would continue to look after in the long term. I was astonished at the emotional impact the three-year-old boy had on them, particularly the foster mother, and saddened when, within six months of being placed, he was removed from the placement as the carers felt they could no longer cope. This meant a separation from the carers and their family, as well as from his brother who was, of course, a hugely significant figure in his life, albeit a troublesome one. It seemed as though something had got inside foster mother and she saw in the boy something monstrous and unmanageable, something violent and too damaged – something which she felt she could neither understand nor bear. Something had also got into the child, who was behaving in a most distressing way, screaming, hitting out at adults and children, and biting his arms whilst in a rage. I began to wonder why and how it had gone so wrong and if there was anything which could have been done to prevent it. What were the factors at play in this situation, with such a distressing outcome, for all concerned?

At that time, my thoughts were also often occupied with a fourteen-year-old boy, then living in a local authority residential children's home, who had had a strikingly similar experience when he was three years old. He had displayed similar behaviour to the child above, screaming for hours on end and banging his fists against the wall until they bled. His carers too had found his distress unbearable and he had been moved to another placement without planning or preparation. This boy is now in a worrying state of mind, not engaging with anyone, without a relationship of any meaning with another human being, but, by his behaviour, giving indications of his internal disturbance, and causing much concern to the adults who are attempting to care for him. I wonder if things might be different for this boy now if it had been possible to think about him differently when he was three years old. I wonder, too, how the carers felt about it, and if they had been able to process the experience in the intervening years.

The work of Fraiberg (1975) and Pozzi (1999) inspired my thinking about work with under-fives and their parents, but I began to wonder how similar or different it is for carers attempting to form a relationship with a child who has experienced significant abuse and neglect, rather than the work with infants and birth parents which they describe. Pozzi (1999: 54) suggests that 'working in the negative transference and being able to bear the negative projections from the family members and if necessary verbalize them can be the only key to open the door to hope'. This follows on from Klein's conviction that the analysis of the negative transference is a precondition for analysing the deeper layers of the mind (1952: 53). I began to wonder about projective processes as they appear in the carer-child relationship, and particularly the impact on carers of negative projections, not only from the children they are trying to care for, but from the wider system around the child.

I chose to focus on under-fives partly because of the current emphasis on early intervention, but also because breakdown of placement at this young age often then becomes a pattern, which is in itself a further damaging and traumatic experience for the child.

Aim of the study

(a) To study the nature of the relationship between a child and their carers in a situation which ultimately led to placement breakdown.

(b) To consider whether psychoanalytic thinking could be helpful in understanding the subtleties of the relationship between carers and child: the unbearable feelings the carers might have had, the unprocessed, raw communication of the child's distress, and how this was experienced by the carer and the carer's family.

Subsequent aims

(a) Ideally, to contribute to the prevention of placement breakdown by bringing more understanding to the factors which lead to this situation.

(b) To propose ways of developing a therapeutic intervention in cases identified as being at risk of breakdown. This could be aimed at specifically referred children and their carers, and, more widely, to fostering agencies and social services so

> that such cases can be identified early, rather than, as currently happens, cases being referred at crisis point and requiring urgent attention and action.

In the next chapter I review the literature, covering a number of themes. This is followed by a chapter on the research design and methods, and includes ethical considerations. Chapter 4 describes the findings of the research and consists of six case presentations. In Chapter 5 I discuss my analysis and interpretation of these findings. The final Chapter is the conclusion with recommendations for practice, policy and further research.

2. LITERATURE REVIEW

2.1 Introduction

The main focus of the literature review is on the caregiving relationship. I look in particular at what happens when carers attempt to care for children who have experienced early neglect, abuse and trauma, and where there have been let-downs in the primary caregiving relationship. I look at how the developing self emerges from and is shaped by experiences within the primary caregiving relationship, and how this impacts upon future relationships, particularly the caregiving relationship between carers and infants in the context of neglect, abuse and trauma.

I have included sections on attachment literature, reflective functioning, and psychoanalytic psychotherapy, although there is some overlap between them. There are a considerable number of articles, as well as entire books, written on these subjects therefore I have chosen those articles which are relevant to my topic and which I have found useful to this study. This has been a challenging process as the potential to be drawn along many different routes is enormous. The key point for this study is the emphasis, from each of these fields, on the caregiving relationship as it is formed and as it continues to cast influence throughout childhood and into adulthood.

There is a significant body of literature on the subject of placement breakdown and the caregiving relationship with children who have experienced early neglect and abuse. However, much of it focuses on the child and types of behaviour displayed by the child. There has been less research on carers and on the relationship between child and carer, although the work of Dozier and colleagues focuses on the development of attachment between infants and carers (e.g. Dozier et al, 2002, and Stovall-McClough and Dozier, 2004).

Searches of E-Library databases, such as PsycINFO and Pep Archive, led to vast numbers of articles on the subjects of ‘caregiving relationship’, ‘foster care’ and ‘placement breakdown’. To keep the literature review manageable, I concentrated my searches on specific journals, mainly *Adoption and Fostering*, *Infant Mental Health Journal*, *Journal of Child Psychotherapy*, and *Clinical Child Psychology and Psychiatry*.

I begin with an introduction to foster care and children who are Looked After by the local authority. This is followed by a brief review of the literature on neglect and abuse, trauma, and a section on neurobiology and the developing brain. I then bring in the research on attachment, reflective functioning, and psychoanalytic psychotherapy. Finally, I include a section on the emotional impact of looking after children who have experienced early neglect and abuse, and a final brief section on institutional dynamics.

2.1.1 Children and Families in Scotland

The Early Years Framework, published in 2009 by the Scottish Government (www.scotland.gov.uk) is an acknowledgement by the Scottish Government of the importance of early years and early intervention, early years being defined as 0-8. The document pledges to provide more help to develop parenting skills within antenatal and postnatal care and a renewed focus on age 0-3. The document notes that parents' interaction with children in the first years of life is critical in developing relationships and laying the foundations for positive physical and mental health development.

More recently, in 2011, as part of the implementation of the Early Years Framework, a guidance document was published, ‘A Pathway of Care for Vulnerable Families’ which aims to ensure that vulnerable children, from conception to age three, and their families, receive support that is ‘equitable, proportionate, effective and timely’. It is intended to be a multi-agency, multi-disciplinary programme working across all agencies to recognise as early as possible those families who are vulnerable and at risk.

In an earlier document, published in 2007, ‘Getting it right for every child in kinship and foster care’, the writers point out that planning for the stability of children ‘must be set in timescales that reflect the child’s developmental needs and not an arbitrary adult timescale’. They call for a renewed emphasis on the period between early pregnancy and three years old, as evidence shows that this is the period with the greatest bearing on outcomes and a critical period in terms of breaking cycles of poor outcomes.

There is, then, a clear political focus on infancy, developing relationships and interaction between parents and infants, and a desire to promote timely planning for the permanent, long-term care of children who are looked after away from home.

As well as the lost childhoods and the damage to children, families and communities, the financial costs of failure to provide adequate care for infants are enormous**.** For example, the annual costs of providing intensive secure care for a teenager can be in excess of £200,000 per annum. The costs of impaired health, lack of employment and criminality throughout life could be much more. There is evidence of a positive economic return from early years investment, i.e. spending on programmes that are targeted, high quality and based on an effective methodology can save more than they cost over a number of years (see www.scotland.gov.uk for all statistics).

2.1.2 Looked After children in Scotland[3]

The majority of Looked After children in Scotland are looked after at home or by friends or relatives (total 59%). In 2011, 24% of Looked After children were in local authority foster care, 7% in purchased placements, a figure which has increased every year since 1993.

The number of Looked After children has increased every year since 2001 and is at its highest since 1981. At 31/07/11 there were 16,171 children looked after by local authorities in Scotland, an increase of 2% since July 2010. The number of children aged under-five at the time of starting to be looked after has increased every year since 2004-2005. It is not clear if this is related to a greater awareness of the needs of young

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[3] Looked After children in Scotland go through the Children's Hearing System. This is the care and justice system for Scotland's children and young people. A fundamental principle is that children who commit offences and children who need care and protection are dealt with in the same system. The Hearing consists of three Panel Members, all trained volunteers from the community, overseen by the Children's Reporter, a professional from either a legal or a social work background.

children, or if it is a reflection of the anxiety aroused by media attention on deaths of children by abuse and neglect.

A recent study by the Scottish Children's Reporter Administration (Henderson et al, 2011) of 100 children under four highlighted concerns about the number of changes of placement many children in care experience, and found that in most cases it took over two years for children to be settled in adoptive homes.

It was not possible to obtain figures for numbers of breakdowns of placement as these figures are not recorded. Scottish Government statistics give figures only for numbers of children leaving care in any one time period, without specifying reasons for leaving care.

2.1.3 Mental health of Looked After Children

Children who are Looked After away from home are at increased risk of developing emotional and mental health problems (Simmonds, 2010). Ten percent of children and young people within the general population in the UK will be diagnosed with a mental health disorder, while up to 50% of Looked After children will be considered to have a mental health disorder (Golding, 2010). The findings are similar from around the Western world.

Emotional dysregulation, indiscriminate friendliness and attachment disorders, as well as mental health problems in general, are commonly found among the population of Looked After children who have experienced neglect, abuse and rejection (see Minnis and Devine, 2001; Golding, 2003; Pears et al, 2008). The prevalence and severity of these disorders increases with the experience of frequent changes of placement and multiple caregivers (Ford et al, 2007).

Schofield and Beek (2005), in a study of 52 children placed for long-term foster care, found that 90% had experienced maltreatment and 93% were rated as having emotional and behavioural difficulties. A study by Minnis and Del Priore (2001) found that more than 50% of looked after children had issues which required input from a mental health service. A survey by Meltzer (2000) found that the rates for mental health disorders in a sample of five-to-ten year olds were 52% for Looked After children compared to 8% of children not Looked After. Simmonds (2010) noted a decrease in the rate of mental health disorders in children and young people linked to the length of time in placement.

2.1.4 Foster Care Recruitment

There is currently a shortfall in supply of carers, described by the Fostering Network (www.fostering.net) as 'a growing crisis in recruitment and retention of foster carers'. A survey by the Fostering Network revealed that at March 2008 there were over 3,000 foster carer households in Scotland, but 450 more foster carers were required to meet the immediate demand for new foster care placements. Sellick (2006: 67) pointed out that foster carers continue to be in short supply and retention of carers remains challenging.

2.1.5 Foster Care in Glasgow

The fostering agency of Glasgow City Council was subject to an inspection in 2010. At that time, there were over 450 foster carers approved by the agency, offering care to 821 children. The inspection reported that this fostering agency was doing well and provided good levels of support and communication with foster carers. However, the inspection highlighted the need for increased liaison with placing SWs to ensure there were no delays in the provision of background information at the time of placement. One of the main dissatisfactions described by carers was the amount of contact with the placing SW (i.e. the child's social worker), citing this as inconsistent and variable depending on the individual SW.

Both the Inspection Report and the Scottish Government documentation have highlighted the need for carers to be skilled, trained and supported.

2.1.6 Choosing to become a Foster Carer

People choose to become foster carers for many reasons: to provide a warm and loving environment for children who have had a difficult start in life; to help children to overcome adversity; for financial reasons; and sometimes for reasons connected with the carer's own childhood, whether or not there is conscious awareness of this.

Cole (2005), in an article on foster caregiver motivation and infant attachment, found that motivations to foster, such as the wish to increase family size, and social concern for the community, were significant predictors for secure attachment. Anderson (2001) conducted a study of 21 families and found four motives for taking care of foster children: relatives who feel responsibility for a certain child; couples who want children and do not think they can have children of their own; a mother who wants to be at home, taking care of children instead of having unskilled work outside the home; and parents with grown-up children who want to fill the 'empty nest' by becoming foster parents.

2.2 The Caregiving Relationship

2.2.1 Introduction

Every child needs the loving care and attention of the primary caregiver. Throughout the literature on the caregiving relationship, the role of the caregiver in helping to regulate the infant's distress is emphasized. This formative relationship is seen as fundamental to the child's developing personality and future emotional and mental well-being. Stern (1998) wrote of 'attunement', Bion (1962) of 'containment', Winnicott (1960) 'holding', Fonagy (1991) 'reflective functioning' and Alvarez (1992) 'live company'. While each of these terms has subtle differences, they each emphasise the significance of the primary relationship, the capacity of the caregiver to tune in emotionally to the infant and to share affective states (see also Lyons-Ruth 1999, Dozier et al, 2002, and Grienenberger et al, 2005).

Awareness of the importance of this primary relationship has entered the forefront of childcare practice and books continue to be published on the subject (e.g. Gerhardt, 2004, Perry, 2006, and Music, 2011).

2.2.2 Foster Care

Foster care has been described as ‘the principal placement of choice for children and young people in public care in the UK’ (Sellick, 2006: 68). However, the idea of foster care as an intervention has been called ‘problematic’ (Zeanah et al, 2001). Although many of the problems experienced by children in foster care have arisen from experiences of abuse and neglect in their original families, it is possible that foster care itself may contribute to poor adaptation, at least for some children. Minty (1999: 991) noted the strong ideology in both the USA and the UK that ‘foster care is not parenting’. Wilson (2006: 497) wrote of ‘the need for a theory of foster care as an environment for change’, noting that foster care ‘is rarely seen as a place where change takes place’.

Bates and Dozier (2002: 419) noted that ‘foster mothers face a very different set of circumstances’ than birth parents. They wrote of the ‘joyful anticipation’ of the birth mother, awaiting the arrival of her new baby, while foster mothers often find themselves caring for children who reject their care and push them away. Furthermore, foster mothers ‘live with the fact that the infant may be removed from their home at any time and with very little notice’.

Children placed later, and having been longer exposed to maltreatment, are more likely to need therapeutic caregiving (Stovall and Dozier, 2000). Hughes (1999: 295) believes that placing children with alternative families with the opportunity for security and new attachments is not enough to reverse the damage of early experiences (see also Cairns, 2008: 92). Cairns (2008) differentiates between adoptive carers, whose motivation is to be a parent, and professional carers who foster traumatised children.

The complexity of the foster caring task was noted by Barratt (2002: 167) and the risk that carers will stop fostering because they are expected to do 'the impossible' in relation to their contact with all aspects of the system and the child.

2.2.3 Short-term Foster Care

Goldstein, Freud and Solnit (1980: 24) noted that children placed in foster homes on a temporary basis are at a distinct disadvantage because such a situation militates against 'any deep emotional involvement with the child'. Equally, carers are at a disadvantage because they have 'no more than partial protective power' (1980: 25) over the child. As they point out, having full guardianship of a child allows the carer to develop 'tolerance, endurance, and devotion'.

Short-term foster care can be thought of as a transitional phase, leading to a return home for the child, or to adoption or long-term fostering. Transitional equates to impermanence, not lasting. Ironside (2004) named temporary care arrangements 'living a provisional existence', for both child and carer. Cooper and Webb (1999: 123) wrote of this state of impermanence as being like a kind of 'borderline state' to the children who experience it, and they wonder too what this state of impermanence does to the carers' state of mind. Residing in temporary, short-term placements can have profound effects on a child's developing sense of self and their location in space and time. Canham (1999) wrote about a child's acquisition of a sense of time being affected by sudden, unexplained moves and remaining for years in short-term, impermanent placements. Kenrick (2000) emphasised the need for therapeutic help as early as possible for children in transitional placements.

Conversely, there are times when a child does make a significant attachment to a short-term foster carer, and then has to move to a planned permanent placement, whether adoption or long-term fostering. Lanyado (2003: 338), writing about children who have made attachments to foster carers whom they then have to leave, compared the experience of moving from fostering to adoption as being like 'surgical removal'. It is a striking image, for all children who have to move to a new family, with ‘the worrying risk that the transplant will not take’.

2.2.4 Permanence

Securing permanence for children is always the aim for children who have been removed from their family of origin, whether that is a move to permanent foster care or adoption, or a return to their birth family. Delays in securing permanence are common despite the knowledge that this has a negative impact on children. Cooper and Webb (1999) found that conflict about planning was a persistent theme and led to delays and undermining of attempts to secure permanence. Barratt (2010: 630) noted the complexity of decision-making, and the number of people who can be involved, and that ‘decision making can still be too slow for children’.

2.2.5 Placement Stability and Breakdown

There are few studies which directly ask foster carers for their views on the challenges of being a foster carer. In one such study, Brown and Bednar (2006) asked carers what would make them consider ending a foster placement. They looked at factors which might predict placement breakdown; in particular, factors specific to the child, to the carers, and to the relationship between them. They noted that it is the interaction between child and carer which is more predictive of breakdown than the personal characteristics of either one. The equal importance of child and carer characteristics is noted also by Bifulco et al (2008). Despite this finding, much of the literature on placement breakdown lists factors external to the relationship as being a causal factor.

Reviewing the literature on placement breakdown led to a potentially confusing range of possible factors which lead to placements breaking down. I have summarised and grouped these under five headings as follows:

1. ***Types of behaviour in child***: Serious physical or sexual harm by a child (Brown and Bednar, 2006), behaviour of a physical or sexual nature, which threatened the carer and their family e.g. sexualised and/or violent and aggressive

behaviour, and behaviours that carers considered disturbing, such as self-harm, drug misuse and criminal behaviour (Sargent and O'Brien, 2004) were seen as risk factors, as were children with severe behaviour problems (Meier, 1987) and those displaying multiple problem behaviours prior to entering care (McCarthy, 2004). Chamberlain et al (2006) found that the number of problem behaviours described by carers was related to the risk of placement disruption during the following year, and that the threshold for number of problem behaviours per day that carers could tolerate was six. Strijker et al (2005) identified two categories of children vulnerable to placement breakdown: withdrawn children and aggressive-delinquent children. While Price et al, 2008, found that child behaviour problems contributed significantly to placement changes, and the number of prior placements was predictive of 'negative exit', behaviour problems were noted as both a cause and a consequence of placement breakdown by Newton et al (2000), highlighting the relationship between 'problem' behaviour and placement breakdown – which came first?

2. ***Carer characteristics***: When carers are motivated to be loving parents and wish to protect children from harm, they are more likely to be successful (Rodger et al, 2006). Street and Davies (1999) found that success was more likely when there had been thorough preparation for the child's arrival and preparing carers to understand that 'love is not enough'. The idea that by providing a child with love all will be well is a naive and idealistic belief which fails to recognise the powerful and even insidious effect of the unconscious communications of both children and caregivers. Mental preparation for the placement is mentioned by Larkin (2006) as an important factor, as is belief in their influence on infants' development (Dozier and Bates, 2002). Brown et al (2007) discovered that foster carers would consider ending a placement if they felt burned out or had insufficient information about the child. One study found that placing a child in a family described as 'infertile' i.e. having no birth children, carried the lowest risk for breakdown (Kalland and Sinkkonen, 2001).
3. ***Issues pertaining to the relationship***: lack of 'fit' between carer and child (Brown and Bednar, 2006); Wilson (2006: 498) calls this 'chemistry', noting

that success is more likely when the child wants to be fostered and has lower levels of disturbance, and when the carer is warm and child-oriented; degree of willingness to modify expectations by both carer and child (Brown and Bednar, 2006); children and carers who see similarities in each other are more likely to do well (Street and Davies, 1999). Wilson (2006: 499) suggests the possibility that 'difficult children produce carers who parent less skilfully', pointing to the effects of the interaction between the two. Levels of challenging behaviour in young people were found by Morgan and Baron (2011) to be significantly associated with increases in stress, anxiety and depression experienced by foster parents. 'Emotional expressiveness' in both carer and child is named as an important factor by Street and Davies (1999), and whether or not carers expect a child to talk about their feelings. The capacity to talk about feelings is linked to the achievement of reflective functioning (Fonagy and Target, 1997) (see Section 3.7).

4. ***Factors relating to child's background***: children who were very young when first removed from home, and children having parents with problem drug or alcohol use, were found by Meier (1987) to have had the most disruptive experience in foster care. Previous breakdown was cited by Street and Davies (1999) as a precipitating factor for subsequent breakdown. Strijker et al (2008) found associations between number of placements and prevalence of attachment disorders, severity of behaviour problems and breakdown of new placements. Children who have had at least some good experiences during the first year of life are more likely to have good outcomes. Kenrick (2009: 15) suggested that children who had fewer moves of placement or cumulative separations had fewer difficulties with attachments. Parental rejection was noted as a significant factor in the poor outcomes for accommodated children (Cameron and Maginn, 2008). Children who had been 'preferentially rejected' by birth parents and placed singly (away from siblings) were associated with poorer outcomes (Rushton and Dance, 2003 and Dance, Rushton and Quinton, 2002).
5. ***External factors***: quality of relationship between carers and social worker, highlighting the need for respect and feeling valued (Brown and Bednar, 2006);

> poor relationships with other professionals was linked to considering giving up fostering (Rodger et al, 2006); conflict with other children in the household (Ingley and Earley, 2008); and the presence of a child of the same age living in the placement (Street and Davies, 1999).

This is a snapshot of the factors cited in the literature as having a role in placement breakdown. The reasons for breakdown are many and complex, accentuating the need to pay attention to all aspects of the situation, not just the external circumstances surrounding and affecting the placement, but also the individual characteristics and circumstances of both child and carer, and the interaction between them.

2.2.6 Support for carers

Rostill-Brookes et al (2011) cited lack of support from agencies as a main factor in placement breakdown. In a study by Murray et al (2011: 149) foster carers reported 'substantive, unmet needs for support and training'. Support was viewed by Bifulco et al (2008: 34) as 'equally critical to that of parenting capacity in determining the success and stability of future placements'. They noted that assessment tools are needed 'to measure the quality of support and carers' ability to access it'. Post-placement support is also noted as an important factor (Street and Davies, 1999, and Kenrick, 2010).

Carers value support services which are readily available and understanding of the emotional demands placed on them (Sargent and O'Brien, 2004). Appropriate emotional support is cited by Cameron and Maginn (2008) as key to promoting the successful development of accommodated children. However, carers are often wary of asking for support, for fear of being seen as not coping, of being judged, and lack of confidence in effective services (see Rostill-Brookes et al, 2011 and Conway, 2009).

In a paper on the development of attachment relationships over the first two months of placement, Stovall-McClough and Dozier (2004) concluded that interventions and support for carers need to begin much sooner after placement than is typically provided.

2.2.7 Birth family

It is beyond the scope of this study to go into any detail about birth parents so I mention here only some thoughts about how they might feature in foster placements.

Birth parents can exercise a powerful effect in the minds of both carers and children, stirring up feelings of rivalry, envy and blame in foster families and in the system. The birth family of the foster child, as well as the birth family of the carers, can play a crucial role in the success or otherwise of a placement (see Rostill-Brookes et al, 2011). The relevance of both the child's and the carer's thoughts, feelings and beliefs about birth parents is noted by Street and Davies (1999), Emanuel (2002) and Lindsey (2006). Loxterkamp (2009) has drawn attention to the conflicting views on whether contact with birth parents is important to maintain family bonds and identity, or if it undermines the relationship with the new foster family.

2.3 Neglect and abuse

There is a wide-ranging literature on neglect, abuse and maltreatment and it is not possible to provide a comprehensive review of all the relevant literature. I am giving here a selection of writings which are relevant to the study.

A recent publication by NSPCC (Cuthbert et al, 2011) highlighted that infants are a particularly vulnerable group and are significantly more at risk of death by maltreatment than any other age group across the life span. More children die from abuse and/or neglect during the first year of life than any other year throughout childhood (Zeanah et al, 2001). Ward et al (2012: 16) noted that very young children are 'over-represented' in national statistics on safeguarding children, but also that 'abuse is substantially under-reported'.

Despite increasing awareness of the effects of neglect, Daniel et al (2010 and 2011) found that recognition of neglect is inconsistent. Furthermore, while professionals can identify signs of neglect, they are not always clear about the best response.

It is well documented that neglect and maltreatment lead to disruption in the child's ability to form secure attachments and develop healthy, well-functioning relationships (see Ward et al, 2012). Music (2011: 202-204) noted the effects of different forms of neglect, from children whose main caregiver does not pick up on or respond to the infant's signals, to children who have experienced severe neglect in Romanian orphanages. Music (2011: 93) referred to studies with severely deprived and neglected infants, such as those adopted from Romanian orphanages, where parts of the brain were seen to have atrophied.

Howe (2005) in his book, *Child Abuse and Neglect*, divides abuse and neglect into distinct categories: physical child abuse; psychological maltreatment or emotional abuse; neglect; and compound cases of abuse and neglect. He describes how the different kinds of abuse and neglect affect the child's attachment system and developing sense of self and others.

Glaser (2000: 98) noted that the definition of child abuse and neglect includes 'single events, repeated events, or a pattern of interaction that is characteristic of the relationship between the abuser…and the child'.

In their book, *Psychotherapy with Severely Deprived Children*, Boston and Szur (1983) challenged the view that psychotherapy may not be possible with children who have experienced neglect, abuse and deprivation and wrote of the potential healing which could come about through psychotherapy. Hunter (2001) and Kenrick (2006) have noted the opportunities for therapeutic work even with those children in short-term foster placements.

2.3.1 Perpetuation of deprivation

The experience of inadequate care and relationship disruption often leads to children behaving in ways that fail to elicit caregiving, and even to actively reject it, so that the original deprivation is perpetuated (Henry, 1974; Hopkins, 2000). Henry (1974), from a psychoanalytic perspective, wrote of the effects of deprivation and rejection leading to a 'double deprivation', the original being the external deprivation, which was beyond the child's control, and the second being the deprivation arising from internal sources, and the 'crippling defences' the child then sets up. Hoxter (1983: 126) warned against being drawn into a 'cycle of deprivation' when working with deprived children, when children provoke similar feelings and defences to their own, by use of projective processes.

Howe and Fearnley (2003), from a social work and attachment perspective, wrote of the relationship style of the child, and of the carer, and the significant role they play in the formation of the new relationship. Children who have experienced neglect and abuse bring 'controlling strategies' to the relationship with new carers (Howe, 2003: 266). These are children whose early experience has been that being cared for is dangerous and frightening.

Survival strategies adopted by the children continue to be used long after they are required. 'Children bring to the new parent-child relationship their own unique histories, along with the mental states and associated behavioural and relationship styles formed in their earlier caregiving environment'…when such children are:

> removed to a safe family environment, the strategies they developed to help them survive situations of abuse and neglect continue to be employed in the new caregiving environment (Howe and Fearnley, 2003: 371).

Dozier et al (2002a: 541), writing from an attachment perspective, identified 'three critical needs' of infants in foster care. The first of these needs is to provide services to foster parents that 'help them to reinterpret children's behavioural signals', when children 'tend to give behavioural signals that lead even nurturing caregivers to provide non-nurturing care'. The second need is to target 'caregiver difficulties in providing nurturance'; and the third is to help caregivers to 'provide children with a predictable interpersonal environment', for children who are 'at risk for behavioural and biobehavioural dysregulation as the result of disrupted relationships with previous caregivers'.

2.4 Trauma

Central to the psychoanalytic view of trauma is that a traumatic event 'stirs up without fail the unresolved pains and conflicts of childhood' (Garland, 1998: 4). Emphasis is placed upon the meaning of particular events to the individual who has experienced them. Particularly for children with adverse early experiences, a traumatic event can cause serious disruption and disorganisation. Freud (1926) wrote of the 'helplessness' experienced in a traumatic situation.

For children, who are still developing a sense of self or personality, their stage of development must be taken into account. The immature ego is unable to cope with the traumatic event and is overwhelmed, with serious consequences for development (Osofsky et al, 1995; Emanuel, 1996). Osofsky et al (1995) noted the importance of the support and emotional availability of parents and other caregivers in alleviating the effects of a traumatic event, or cumulative events.

Experiences of trauma and neglect lead to high levels of cortisol, the hormone linked to stress, rather than the helpful and calming hormones which are released with loving care (Music, 2011: 92). Children who have experienced trauma and neglect often become either chronically hyper-aroused or they become shut down and under-aroused, as seen in dissociation (see Osofsky, 2004, Perry, 1995, Music, 2011). Perry (2006: 249) calls this the arousal and the dissociative continuum where two neuronal response patterns are seen – fight/flight or freeze/surrender.

The effects of trauma are particularly significant to the caregiving relationship as the child who has experienced trauma continues to behave as though under threat of danger, even when removed from danger. They are less able to trust that a caregiving adult can provide safe and predictable care and more likely to rely on themselves than look to others for care. 'Typical traumatic stress responses – numbing, avoidance and hyper-arousal – interfere with the ability to rely on others for help' (Osofsky, 2004: 125). Hendriks et al (1993: 11) noted that 'the children most profoundly affected by post-traumatic stress symptoms were those who were most at risk for their lives and least protected by an adult'.

'Structure, predictability and nurturance are key elements to a successful early intervention with a traumatized infant' (Perry, 1995: 291) and the key person to help with this is the primary caretaker. It is, therefore, 'critical to help the caretakers understand as much about post-traumatic responses as possible'.

2.5 Neurobiology and the developing brain

Over the last twelve years there has been extensive research into the developing brain. For the purposes of this review, I have selected those works which are relevant to the topic under discussion, i.e. the importance of the caregiving environment and the inter-connection between caregiver state of mind and the infant's developing brain.

Unlike physical growth, which proceeds in a fairly steady manner from birth until approximately age twenty, brain growth shows a different pattern. Already, in utero, the brain has gone through a rapid rate of growth, and then, from birth to age four, the brain grows explosively. In fact, the brain of the four-year-old is ninety per cent adult size (Perry, 2006: 247). This highlights how important – and how vulnerable – are the early years of life: 'because the brain is most plastic (receptive to environmental input) in early childhood, the child is most vulnerable to variance of experience during this time' (Perry et al, 1995: 276).

The neurobiological literature confirms what psychoanalysis has long been aware of: the significance of early experiences for later development (Balbernie, 2001). The research from neurobiology points to the crucial nature of the primary caregiving relationship for the developing brain of the child and the child's capacity for internal regulation of emotional states. The infant is born 'genetically programmed to connect with caregivers' (Balbernie, 2001: 69). The foundations for mental and emotional processing are laid down within this relationship. As Siegel (2001: 81) wrote: 'the emotional processes of the more mature adult mind can be used by the child to regulate her own internal state' and 'a child uses the state of mind of the parent to help organise her own mental processes'. Parents must provide 'scaffolding' for the infant to communicate his mental states (Lyons-Ruth, 1999: 583). Schore (2001: 2) wrote that 'studies in developmental neuroscience now emphasize that the development of the infant's emotional brain is directly and actively influenced by his transactions with the animate social and not the inanimate physical environment'.

The interpersonal relationship with the other and the emotional connection with the caregiver are emphasised throughout the neurobiological literature: 'The caregiving environment has a specific impact on the infant's maturing brain as it is automatically creating neural circuits that mirror his experiences' (Balbernie, 2001: 238). Schore (2001: 3) wrote of 'the need for intimate relationships and companions in the growth of brain and personality', and Siegel (2001: 90) that 'shared subjective experience is one of the most important aspects of human relationships and of psychological development'. It also prepares the individual for 'collaborative and co-operative existence with others' (Fonagy et al, 2007: 291). Perry (2006: 243) wrote that:

> the mirroring systems of our social brains make behaviours contagious...this is wonderful when what you are practicing is sports or piano or kindness, but not so great when what's being repeated is impulsive, aggressive responses to threat.

As Music (2011: 93) noted, 'experience affects the brain, particularly very bad experiences such as of severe trauma or neglect'.

What all this points to is the importance of environment and the individual's particular experiences with the adult or adults looking after them: 'experience involves the activation of neurons in the brain that respond to the sensory events from the external world' (Siegel, 2001: 69) and 'the prime task of brain development in first few years of life is the forming, and then reinforcing into permanence, of necessary connections' (Balbernie, 2001: 239). Neglect, or the absence of certain experiences, means that these neurons will not be activated. Siegel (2001: 72) referred to neglect and abuse or excessive stress as 'toxic conditions', which can lead to the 'elimination of existing synapses'. This is the 'use-it or lose-it' phase, as Siegel calls it, or what Perry calls 'use-dependent' (Perry et al, 1995). In short, 'severe stress is toxic for the growing brain' (Siegel, 2001: 83).

The human, emotional connection is emphasised time and again. Of course, it is not possible for an infant and caregiver to be in a state of constant connection and throughout the passage of a day there will be periods of greater and lesser connection. However, what I am concerned with here, are situations where there have been prolonged periods of disconnection, which, 'especially if combined with hostility and humiliation, can have significant, negative effects on a child's developing sense of self' (Siegel, 2001: 79). In good circumstances, the caregiver can repair the situation and reconnect with the infant but, in situations like those of the children we see in this sample, this is often not the case and the periods of disconnection and misattunement extend into time periods which have serious consequences for the child's developing brain. Glaser (2000: 110) wrote that 'there is considerable evidence for changes in brain function in association with child abuse and neglect'. Glaser (2000: 98) drew attention to the possibility of the different effects on the brain of event-type abuse and relationship-type abuse, noting that 'physical and sexual abuse are in the nature of *events*, neglect and emotional abuse characterise the *relationship* between the carers and the child' (author's italics).

This highlights how difficult a child's task will be to tune into and use the 'more mature adult mind' (Siegel, 2001: 81) of the carer following the experience of repeated misattunement and failure to make reparation. As Slade (2005: 273) wrote, 'in instances of severe abuse or traumatisation, taking on the parent's mind may be too terrifying, and potentially annihilating. Sharing his mind with the caregiver becomes dangerous, rather than a rich opportunity for self-knowledge and emotional containment.'

2.6 Attachment

Attachment theory was conceived by Bowlby (1969) as a means of defining the behavioural systems which are activated within the caregiving relationship. It is a theory with wide-ranging influence, commonly taught on social work and health courses, with ideas filtering down to foster carers. Bowlby (1979: 131) postulated that attachment behaviour was activated not just to meet the needs of primary and secondary drives (e.g. food and sex) but as a need in its own right: 'thus attachment behaviour is conceived as a class of behaviour distinct from feeding behaviour and sexual behaviour and of at least an equal significance in human life'.

Attachment theory is a theory about protection (Howe, 2005). In the child attachment system, the child seeks protection, while in the caregiver attachment system, the caregiver provides protection. However, the attachment relationship is crucial to all areas of development for the young child, not just the provision of protection and a sense of safety. Fonagy and Target (2005: 334) cite the attachment relationship as a 'major organiser of brain development'.

For the child, there is a continually shifting balance between the need for safety and closeness to the caregiver, and the desire to explore and learn about the world, which increases the distance between them. When the attachment system is activated, due to fear or distress, the child seeks proximity to the caregiver, and attempts to maintain closeness to her. When the child feels secure in the knowledge that the caregiver is available, he is confident to move off to explore. Bowlby (1969: 236) wrote of the 'dynamic equilibrium' between a mother and child. He referred to the patterns of behaviour which can be seen over the course of an ordinary day, the regulation of distance and proximity which takes place, depending on the activity of either member of the couple. This is something to which both mother and child are continually adjusting throughout the day, a fluctuating process which gains or lessens in intensity depending on what is going on. Bowlby noted that, even in a happy couple, 'risk of conflict is ever-present' (1969: 237).

Bowlby (1969: 237) drew attention to the role of both parties within the caregiving relationship and the interaction between them: ‘a child’s attachment behaviour is one class only of four separate classes of behaviour – two intrinsic to the child and two to the mother – that go to make up mother-child interaction’. Two of these classes of behaviour are the attachment behaviour of the child and the caregiving behaviour of the caregiver; the other two are classes of behaviour which are ‘antithetic’ to attachment and to parental care, i.e. exploratory behaviour and play.

Solomon and George (1996) have drawn attention to the caregiving system as a separate behavioural system which should be seen as a behavioural system in its own right, and one which they say has been somewhat neglected in research.

Bowlby was writing in the context of the relationship between an infant and his birth mother. The process of forming healthy attachments, and finding a comfortable equilibrium, becomes much more complicated when it is a new relationship, formed between a child and a carer, particularly when the child has experienced neglect and abuse.

2.6.1 Disorganised attachment

Initially, children were classified as displaying secure or insecure categories of attachment behaviour, with insecure attachment being divided into either avoidant or ambivalent behaviour, depending on their caregiver’s responses. Later, (Hesse and Main, 2000) a further category was identified, disorganised attachment, to describe those children whose attachment behaviour remains active or unresolved. Disorganised attachment, the ‘D’ category, is seen as the most worrying category, when children display high levels of stress, hyper-alertness, and helpless and/or hostile behaviours (Music, 2011: 68). Behaviour is usually either out of control or controlling. Children in the ‘D’ category become extremely distressed and experience high levels of dysregulation due to denial of their needs and rejection by the caregiver (Howe, 2005: 38).

A key feature of disorganised attachment is that the child experiences the caregiver's behaviour as frightened or frightening (Steele, 2004: 484). When this occurs, the infant is placed in an unresolvable paradox (Lyons-Ruth, 1996: 69) or what Main and Hesse (1990) called an 'unsolvable dilemma', i.e. when one's main source of comfort and nurturance is a figure who arouses fear and distress. Hopkins (2000: 345) calls this 'fright without solution' and writes that these children will erect 'two barriers to making new attachments in adoptive homes: a deep distrust of relationships and a defensive armoury which protects them from intimacy' (2000: 338).

Lyons-Ruth (1996) found that a lack of responsiveness to the infant's cues and the caregiver leading communication in a way that ignores or denies the infant's communications, leads to disorganised attachment and a subsequent risk of aggressive behaviour.

2.6.2 Disorganised caregiving

The relationship histories of infants and their caregivers are key in relation to the attachment styles developed by infants. When caregivers reject their infant's requests for help and reassurance, the infant tends to develop an avoidant attachment style; when a caregiver is inconsistent in the provision of caregiving, this tends to lead to resistant attachment; and when caregivers behave in frightened or frightening ways, the infant develops a disorganised attachment style, referred to as a 'breakdown in strategy' by Dozier et al (2002: 544).

The Adult Attachment Interview, devised by Howard and Miriam Steele (Fonagy, Steele and Steele, 1991) shows how the future attachment status of an infant could be predicted using the AAI, a tool which reveals a mother's ability to reflect on her own attachment experience and to produce a coherent narrative (See Music, 2011: 16).

Results of a study by Solomon and George (1996) confirmed that evaluations of the self as helpless are associated with disorganised caregiving. Carers are often pushed into feeling helpless, propelled into a negative or disorganised style of caregiving when the goal of their caregiving is thwarted. Mothers classified as secure described self and child in a positive and realistic way, whereas 'rejecting mothers' described 'the self and child as unwilling and unworthy to participate in a relationship' (Solomon and George, 1996: 209). They suggest that under stress, traumatic or painful memories are more likely to be activated, leaving the caregiver feeling helpless and unable to cope.

Wilson (2006: 506) wrote of the balance between caregiving behaviour and self-defensive behaviour. In her study of support for foster carers, insecure carers had high levels of self-defence, while secure carers tended to see the child as a 'challenge' rather than a 'threat'. When the child is seen as a threat the self-defence system is aroused rather than the caregiving system.

Kaniuk, Steele and Hodges' (2004) study of late-placed children (i.e. aged 4 to 8) found that carers of these children described more feelings of anger and hostility, more need for support, and more aggression and rejecting in their children. Those children who had had more previous placements were reported to have higher levels of aggression and to be more controlling and rejecting (Kaniuk et al, 2004: 65). The carers of the early-placed group (i.e. before 12 months of age) reported more feelings of joy, competence and confidence. However, the carers assessed as having unresolved attachment status were more likely to feel rejected and hurt by a child's hostile, destructive or rejecting behaviour.

Steele et al (2003) suggested that reparation of disconnection and mis-cueing is one of the critical elements in the caregiving relationship with adults with unresolved attachment status.

2.6.3 Internal working models

Internal working models, or internal maps of the environment, are built up over time. These 'detailed representation(s) of the world' (Bowlby, 1969: 49) or internal 'mental representations' (Howe, 2005: 28) of the attachment relationship, are built up through repeated interaction with the caregiver, or 'dyadic experiences' (Hodges, 1990: 60), and act as a kind of template of significant relationships. Over time, these internal working models, or mental representations, are depended upon more than the actual attachment figure, as the need lessens for the actual presence of that person. This is why the nature of the early relationship is so important as it is formative in shaping the child's view of self, of others, and of relationships (Howe, 2005: 29).

Negative internal working models are constructed from a relationship which is neglectful, rejecting and/or abusive. In situations of rejection and neglect, the child may perceive the parent as unloving and internalise an idea of the self as unlovable (Hodges, 1990). Negative images of the self are difficult to shift, but can become less potent over time from within a supportive, loving environment. Hodges et al (2000: 453) found that negative internal working models do not disappear in the context of a new and positive caregiving relationship, but 'alternative, competing ones get developed and may even become dominant'.

2.7 Reflective functioning

Reflective functioning is defined as the individual's capacity to mentalize, and to have an awareness of one's own and others' thoughts and feelings (see Fonagy et al, 1991; Fonagy and Target, 1998; Fonagy, 2002). Reflective functioning and the reflective self refer to the 'internal observer of mental life' (Fonagy et al, 1991: 202) and the process of reflecting on conscious and unconscious mental experience. Fonagy et al (1991: 203) asserted that the 'reflective-self function' is 'an essential step in emotional development during early childhood'.

Reflective functioning incorporates ideas from attachment and psychoanalytic literature to produce another way of explaining internal mental processes which affect not only individual behaviour but how an individual behaves within relationships. Without the capacity for reflective functioning one is open to others' projections and lacks the ability to differentiate between self and other in order to reflect upon experience.

2.7.1 Parental Reflective Functioning

Fonagy et al (1991: 207) noted the 'central role' which reflective functioning and the reflective self play in parenting, and emphasised the importance of the interpersonal nature of the reflective self, which 'evolves in the context of the infant-caregiver relationship' **(**1991: 203). Parental reflective functioning refers to the parent's capacity to hold the child's mental states in mind, and to reflect on their own and the child's mental experience. It is a key aspect of the sensitive caregiving role and promotes not only the child's development, but also his growing capacity to conceive of others' mental spaces.

The absence of Reflective functioning can lead to various forms of psychopathology (see Slade, 2005 and Grienenberger et al, 2005). Maltreated children are likely to struggle to acquire an accurate representation of themselves in the mind of the maltreating caregiver and are therefore more likely to fail to develop reflective functioning (Fonagy and Target, 1997). Learning to label and monitor thoughts and feelings is central to emotional development (Music, 2011: 101).

2.8 Psychoanalysis

2.8.1 Containment

The idea of containment (Bion, 1962), of the mother providing a space in her mind which conveys love and understanding to her infant, is one which is crucial to the infant's healthy development. Bion pointed out that the infant's physical needs are met by a supply of milk and comfort, but that his emotional needs for love and understanding are met by 'reverie'. Bion (1962: 36) used the word 'reverie' to describe the emotional activity of the caregiver in expressing her love for her infant, this being 'the psychological source of supply of the infant's needs for love and understanding', in parallel with the physical activity of providing food and warmth.

A significant function of containment and holding is to provide meaning to the child's experience, or what Bion called 'alpha-function' (Bion, 1962: 6)**.** Miller (1992) wrote that containment has two aspects – holding and focussing; this is crucial in providing meaning and understanding to the child's experience. Miller noted the *active* nature of the process of containment, something which requires not only attention but also reflection on the emotional experience of the infant.

Rosenfeld (1987: 160) described the process of containment in his description of the therapeutic task of the analyst working with psychotic and borderline patients: 'the containing function in fact requires a great deal more than passivity', drawing attention to the active role required of the analyst. He describes situations where there have been failures in early containment, but which mirror the task of the caregiver in providing meaning and understanding to her infant, in the way in which 'the analyst has to bring together the diffuse, confused or split-up aspects of the patient's pre-thought processes in his own mind so that they gradually make sense and have meaning' (Rosenfeld, 1987: 160). He too alerts us to the importance of the container's capacity to process, understand, and return projections in a modified form.

The role of the caregiver is to provide an experience of holding the parts of the personality together, when the infant experiences the various parts of itself as being scattered and has no sense of being bound together (Bick, 1968). The infant needs the experience of internalising an object with the capacity to provide containment, as without this, 'projective identification will necessarily continue unabated' (Bick, 1968: 56) (see section 3.8.2). This highlights the need for a functioning container with the capacity to receive projections.

For the ordinary, average infant then, all being well, this shared experience, of mother having a space in her mind to provide love and understanding, to counteract the sensation of falling apart, leads to the infant having an understanding not only of the experience of being contained, but also the idea of an available container which can provide containment.

Bion (1962: 90) wrote of the idea of 'container-contained', the 'container' being the receptacle of the infant's unprocessed emotions (projections) which then become the ‘contained’. This process leads to the development of thinking and allows the infant, eventually, to develop the ‘apparatus for thinking the thoughts’ (1962: 92). Bion called this process the ‘K link’ (1962: 89), a process of ‘mutual dependency and benefit whereby both mother and baby could grow emotionally’ (Waddell, 1998: 103). ‘K’ is a state of mind receptive to learning, to new experiences, to growth, while ‘minus-K’ actively works against such growth and understanding, i.e. works to promote misunderstanding and absence of growth. Pozzi (2003: 15) described Bion’s notion of ‘container-contained’ as the ‘cornerstone’ of her therapeutic work, which she uses in her work with under-fives and their parents.

The key point of the process of containment, alongside the provision of love and understanding to the infant, of gathering together the fragmented, disparate parts, is that it is a psychological as well as a physical activity, which takes place in the context of a relationship. In Bion’s words, ‘an emotional experience cannot be conceived of in isolation from a relationship’ (1962: 42).

2.8.2 Splitting

According to Klein (1946) splitting is used to keep good and bad aspects of the self and the other as far apart as possible, and as a defence against the anxiety stirred up by fear of the persecuting bad object. This allows the child to keep the ‘good’ mother safe and apart from the denying, withholding, ‘bad’ mother. Splitting is linked to projection, as the infant gets rid of unwanted aspects of the self into the ‘object’ i.e. the main caregiver. In this way, the infant avoids anxiety or pain, or avoids feelings of separation by attempting to control or dominate the object (Joseph, 1987: 161).

In ‘Love, guilt and reparation’ (1937) Klein wrote of feelings of love and hate, originating in the infant’s earliest relation to the mother, the loving feelings which arise when the infant’s needs are satisfied, and feelings of aggression and hatred when the infant is frustrated. Splitting is used as a way of dealing with ambivalence (Klein, 1945). Klein (1935: 288) described ambivalence as ‘partly a safeguard against one’s own hate and against the hated and terrifying objects’.

2.8.3 Projective identification

The term 'projective identification' was introduced by Klein in her seminal 1946 paper, 'Notes on some schizoid mechanisms'. Ogden (1979: 357) noted that this concept 'remains one of the most loosely defined and incompletely understood of psychoanalytic conceptualizations'. Despite this, it has proved to be a useful and much-used concept, with 'considerable clinical value' (Joseph, 1987: 168).

The processes of projective identification and containment are closely connected. The infant communicates his needs and fears to the caregiver by projection, these are received and thought about, and returned in a bearable form to the infant. Grotstein (1981) wrote that for projective identification to occur there must be an object with depth and the ability to contain the projection, and an idea of a container into which the projection can be sent.

While Klein emphasised the role of projective identification as a defence against the anxiety of persecution and the fear of annihilation, Bion (1962: 37) pointed to the role of projective identification as a primitive means of communication used in the service of development. Ogden (1979) and Rosenfeld (1987) outlined the dual nature of projective identification, as a defence *and* as a means of communication. 'Projective identification….is a psychological process that is simultaneously a type of defence, a mode of communication, a primitive form of object relationship, and a pathway for psychological change' (Ogden,1979). Rosenfeld thought of projective identification in two simultaneous ways: one is the expulsive quality of projective identification, the other is the attempt to communicate. He wrote of how projective identification opens the way to dialogue, but how much the success of this depends on the analyst/mother's 'capacity to exist as a container for the patient's projections' (Rosenfeld, 1987: 159).

Joseph (1987) reminded us that Klein named projective identification when writing of the paranoid-schizoid phase[4], characterised by splitting and warding off anxieties and

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[4] Klein wrote of two 'positions', paranoid-schizoid and depressive, the former a state of mind where denial and manic omnipotence, and lack of integration, prevail, the latter a state of mind where concern

impulses, and fear of retaliation by the projected fragments. She, too, pointed out the different aims of projective identification: to get rid of something; to dominate and control; to take over and make one's own; to damage and destroy. It is also used to avoid awareness of separateness or dependence, or envy, loss, anger. This is a description of excessive use of projective identification with a corresponding failure in containment, also noted by Grotstein (1981: 124): 'it is important to realize that projective identification is an unconscious phantasy, in effect, imagination. Employed defensively, projective identification rids the contents of one's mind or, when the experience is severe, the mind itself'. This is vividly described by Henry (1979: 34) in 'Doubly deprived', whose patient, Martin, appeared to be 'devoid of feelings', 'while provoking violent emotions in others'.

In a more recent paper, Ironside (2004: 42) wrote of the foster child getting 'under the skin' of the foster carer 'in a very destructive way'. The child's projection of intolerable feelings evokes similar emotions in the carers, and the need for a capacity in carers to tolerate the projections of the children, to realise that it is *as if* they have been 'invaded' rather than actually feeling invaded (2004: 41).

Reid (1997) drew attention to 'the other side of the equation' i.e. when it is the infant who has been massively projected into, and Williams (1997: 103) to 'the reversal of the 'container/contained' relationship', when the infant is the recipient of 'massive projections'. In such situations, the infant is denied the experience of the use of projective identification, and consequently introjective identification, with negative consequences for the infant's development. Bion (1967: 117) wrote of the 'projective-identification-rejecting-object', where the infant's projections have been rejected by the caregiver, leading to the internalisation of a 'wilfully misunderstanding object'. The idea of such failures in containment was developed further by Williams (1997: 126) who suggests the term 'omega function' to describe the introjection of an object which

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for the condition of the other comes to the fore and the child is said to have developed empathy. These are not fixed positions but are moved between throughout one's life. See Klein 1935 and 1946.

is ‘impervious and overflowing with projections’ and which has the effect of ‘disrupting and fragmenting the development of personality’.

Thus, projective identification can be used in the service of development, contributing to the infant’s sense of safety and idea of self as a separate being. Failures in projective identification, however, can be said to lead to anti-development. A key point for this study, is the interactive nature of projective identification.

2.8.4 Transference and Countertransference

These terms were traditionally written about in the context of a therapeutic relationship, used in understanding the unconscious communications of the patient. ‘In psychoanalysis, conflicts and anxieties are reactivated and are dealt with by the transference of early experiences, object-relations and emotions onto the person of the analyst’ (Klein, 1952: 48). However, these unconscious mechanisms have since been considered as applying in other situations and processes, for example institutional processes. For this study, I suggest that it is useful to consider their operation in the caregiving relationship.

In his 1912 paper, ‘The dynamics of transference’, Freud (1912: 100) wrote of a ‘stereotype plate’, which is ‘repeated’ and ‘reprinted afresh’ throughout an individual’s life. In practice, this means that the child transfers his relationship expectations from his original caregiving relationship to the new caregiving relationship; the child sees or expects to see someone who behaves and reacts as did their original caregiver. Joseph (1985: 156) described transference ‘as a framework, in which something is always going on, where there is always movement and activity’. Steiner (1993: 4) wrote that ‘the analyst is never able to be an uninvolved observer since he is always to a greater or lesser degree enlisted to participate in enactments in the transference’. I suspect that this applies also in the caregiving situation, and that the carer cannot be an uninvolved observer.

The term countertransference was used initially to indicate feelings which the therapist transfers from the past and applies to the client or the client's problem, hence the need for personal analysis and on-going supervision. However, countertransference has come to include the feelings aroused in the therapist, 'as a result of being receptive to the client's transferred feelings', now considered to be 'a most helpful guide to understanding' (Salzberger-Wittenberg, 1970: 255). Heimann (1950) referred to countertransference as an 'instrument of research into the patient's unconscious' and saw it as 'one of the most important tools' for the analyst's work.

Freud (1912: 105) distinguished between a positive and a negative transference and the transference of affectionate and hostile feelings. Winnicott (1947: 195) wrote of the importance of acknowledging and being able to tolerate feelings of hatred towards one's clients: 'However much he loves his patients he cannot avoid hating them and fearing them, and *the better he knows this* the less will hate and fear be the motives determining what he does to his patients' (my italics).

The important point is the capacity to tolerate one's own feelings of hatred towards the child (see, for example, Ogden, 1979, Hughes, 1999, Hopkins, 2000 and Pozzi, 2003) and to accept being hated as well as being loved (Emanuel, 2008). 'It is imperative that a parent or therapist be able to integrate his or her anger and murderous wishes toward their children and patients without enacting these feelings or having to get rid of them through denial and projection', (Ogden, 1979), also noted by Pozzi (2003: 19): 'the hatred does no harm as long as there is awareness of it'.

2.8.5 Emotional availability

Emotional availability, being present for the child, and the capacity to respond with empathy are crucial to the process of successful caregiving (see Hoxter, 1983; Lanyado, 2004; Lieberman et al, 2005.). These capacities provide the child with the right kind of environment for healthy growth and development and protect the child from the trans-generational transmission of trauma, as described by Fraiberg in 'Ghosts in the nursery' (1975) (see section 3.8.6). The degree of emotional availability of the caregiver has a significant impact on the successful giving and receiving of care, particularly for a child who has little or no expectation that care is likely to be reliably available, and that he is worthy of care.

Emotional availability from an attachment perspective is discussed in a special issue of *Attachment and Human Development* (2000, Vol. 2, No. 2). Easterbrooks and Biringen (2000) devised an emotional availability framework which includes four parental (sensitivity, structuring, non-hostility and non–intrusiveness) and two child (responsiveness and involvement) scales.

2.8.6 Ghosts in the nursery

Fraiberg (1975: 88) captured beautifully the way in which unprocessed parental trauma can intrude in the new relationship with the child, with her vivid image of 'ghosts in the nursery': 'while no one has issued an invitation, the ghosts take up residence and conduct the rehearsal of the family tragedy from a tattered script'. The ghosts referred to are 'the repetition of the past in the present' (1975: 89). Fraiberg's work, and that of those who followed her, focused on helping vulnerable and at-risk parents to become aware of how their own trauma or unmourned ghosts, got in the way of successful parenting, often leading to serious symptomatology in infants.

Fraiberg's hypothesis is that when a parent has access to the pains and losses of the past, when painful experiences are remembered and reflected upon, then the ghosts of the past are less likely to take hold. The children in this study were not freed from the 'ghosts in the nursery'; their parents were unable, or had no opportunity, to banish the ghosts from their nursery. The foster carers, too, had ghosts, the cumulative losses of previous children, as well as their own personal ghosts.

Fraiberg and her colleagues provided intensive therapeutic input to the relationship between the caregiver and the infant, focusing on the dynamic interaction between them, and on identifying the role of potentially harmful projections. They paid attention to the baby as imagined or created by the caregivers, referred to by later writers as the 'real-baby/imaginary baby dichotomy' (Watillon, 1993), 'narcissistic scenarios of parenthood' (Manzano et al, 1999) and 'parental constructions of infants' (Lieberman et al, 2000: 472).

Manzano et al (1999) suggested that enactments are observable in varying degrees in all parent-child relationships, and give an example of a mother who projects the image of her own unmourned father onto her baby. They wrote, 'to paraphrase Freud, the shadow of the parents may be said to have fallen on the child, either directly or by way of the shadow of the parental internal objects' (1999: 466). This phrase is helpful when thinking about children in foster care and how their birth parents may cast a shadow on the placement.

Barrows (2008: 181) from an idea of Heimann's in 1942, used the phrase 'unassimilated objects' which make their presence felt across the generations. This refers to the kind of object which has been lodged by parental projection, rather than acquiring and hence 'assimilating' something by experience. In such cases, the child needs to be freed from the parental projections and the parents need to be helped to make links to their own childhood experiences. Baradon (2002: 25) referred to a 'negation of infantile needs' and the inability of the mother to 'mentally embrace'(2002: 26) her baby, when the parental mind is in the grip of preoccupation with its own mental state.

Pozzi (1999: 58) wrote of the children who were brought to her clinic by birth parents: 'A child who is a mixture of what the child really is and of how the child is seen through the lenses of parental projections and confusions with their own childhood is brought to the clinic'. Pozzi wrote of the 'circle of mutual projections of the child on the parents and vice versa' (1999: 70) and how this is re-enacted in the transference with the therapist. I wonder about the added complication, or the 'extra layer', when we are thinking about children who are living within a substitute family. In the case of a child in foster care, the circle of projections begins with the birth parents' projections into the child and vice versa, continues with the child's projections into the carer, and the carer's projections into the child. This gives an idea of the complexity of the situation in which a carer can find herself when looking after a child with early experiences of neglect, abuse and trauma.

2.9 Emotional impact of caring for children

Taking on the task of looking after a child who has experienced severe neglect and/or abuse is a major undertaking, an 'exceptional burden of care' (Murray et al, 2011). The following description of the vagaries of the weather and the exhausting demands of her task, written by Ellen MacArthur (2002) in her account of her solo sail around the world, and the way in which she has to stand by a decision, not knowing if it will bear fruit, is a vivid metaphor for how a foster carer might feel when struggling to get to know, or familiarise herself with, a child in her care:

> *The hardest part out there is assessing the weather, especially when you're cold and tired. The pressure never goes away, and each time I made a decision, I felt an apprehension, followed by painful hours worrying whether it would pay off. The sheer exhaustion just seeps into your bones, and miles gained or lost against rivals become the core of each day. Win miles, and morale soars. Lose them, and you have to try to harness that frustration to fuel further decisions.*

This describes very well how carers come to feel drained and exhausted, trying to read or judge the 'weather' of a child they have just met, unpredictable, unknown and unfamiliar to them.

Children who have experienced early neglect and abuse tend to have a profound effect on those who are caring for them. Ironside (2004: 41) referred to the 'extreme and dire states of mind' carers experience, a communication of the intolerable nature of the child's experiences, and Miller (2002: 58) of the feelings of failure caregivers can experience when attempts to reach these children fail. Hoxter (1983: 126) noted that our emotional reactions to deprived children 'are likely to be very strong' whether we are therapists or substitute parents, and that the defences aroused are likely to be similar to those of the children. To be fully aware of the child's loss and suffering can feel intolerable and often leads to attempts to distance oneself from such pain and loss.

There is increasing awareness of the emotional impact on carers of caring for such children, and the need for support due to the complexity of the task (e.g. Sargent and O'Brien, 2004, and Allen and Vostanis, 2005). Allen and Vostanis found that the emotional impact of caring for children with a history of abuse and trauma was an overarching theme among the carers. They named four sub-themes as follows: 1) sense of disillusionment and despair 2) self-doubt and self-blame 3) feeling emotionally overwhelmed and unprepared 4) lack of reciprocal attachment from the child.

Emanuel (2002) noted that placements often break down when carers can no longer cope with the feelings of rejection, inadequacy, fear and helplessness projected into them by severely deprived children.

2.10 Institutional dynamics

Defences against anxiety, and against unbearable psychic pain, operate not only in individuals but also in institutions (see Obholzer, 1987, Menzies Lyth, 1988, Woodhouse and Pengelly, 1991, and Halton, 1994). The deeper the disturbance, or the greater the dysfunction of individual children and families, the more primitive will be the defences used; similarly, with institutions and teams within institutions.

Several writers have drawn attention to the way in which professionals working with a disturbed client group tend to take on the disturbance of that client group. Emanuel (2002: 164) wrote of 'organizational deprivation' to describe the processes which take place in the institution, and those working in it. In her paper, 'Deprivation x 3' (after Henry's 'Double deprivation'), she describes her experience of setting up a therapeutic service for looked after children in a social services department. She writes of how 'the trauma and disturbance associated with severe deprivation and abuse within children and families can impact on the professionals involved in their care' (Emanuel, 2002:

163). She describes how the workers' capacity to think and provide containment is affected, thus intensifying the deprivation experienced by the children.

Mawson (1994: 68) in 'Containing anxiety in work with damaged children' writes of how feelings of persecution and hostility towards the children are deflected outwards and into other parts of the institution. Mawson (1994: 74) notes the importance of providing a space to think about the anxieties stirred up by the work. Britton (1981) writes of 're-enactments', when professionals or institutions become unwittingly involved in dramas which rightly belong with the child and the original family. I would add that carers are drawn into such re-enactments when looking after children with these experiences, just as they are subject to the projections of the child. The important point which Britton (1981: 48) makes is that 'this is not recognised but expressed in action'. He notes that one of the indications that enactment is occurring is 'the pressure to take drastic or urgent measures' (1981: 48), which is what we see when carers suddenly declare that they can take no more and ask for a child to be moved immediately. This is described by Woodhouse and Pengelly (1991: 225) as collusion with clients, when professionals enact defences which are 'the same or opposite to those of their clients or patients'. This is an unconscious process which impedes task performance.

2.11 Reflections on literature review

A substantial body of knowledge exists in the fields of attachment, reflective function, developmental neurobiology, and psychoanalytic psychotherapy, in relation to children who have experienced early deprivation, and how this affects their capacity to form and maintain healthy relationships. This has made writing the literature review a challenging task and I struggled to keep it to a realistic size. Providing a summary has meant that I have been unable to go into the detail and depth I might have wished, but it has allowed me to refer to the major theories referred to in the literature on children with experiences of early maltreatment.

Developmental neurobiology research has drawn attention to the crucial importance of the caregiving environment for the infant's developing brain, and his emotional and psychological development. This body of research has greatly advanced our understanding of how an infant's brain is shaped by shared subjective experiences with the primary caregiver.

Ideas from attachment theory have become firmly established in the field of child care and child health. The presence of a safe and reliable adult who provides a 'secure base' (Bowlby, 1979: 103) for the child's explorations and returns, is now recognised as a fundamental need for every child.

The writings of Fonagy and his colleagues, and the development of the idea of reflective functioning, have been helpful in stressing the importance of the capacity to create and maintain a reflective space, an ability to stand outside oneself, as it were, and think about both one's own and another's mind. This is related to what the psychoanalytic community refers to as a space for thinking. Such a reflective space becomes essential when anxiety-provoking thoughts and feelings, and defences against them, are regularly aroused.

These theories attempt to explain infant development and behaviour, and, in particular, infant development in relation to a caregiving adult. They are also theories which attempt to understand processes of the mind, hence internal working models, mentalization, projective identification, and re-enactments, and defences arising in the system.

While reviewing the literature, I became aware of the concurrence between these fields on the profoundly disruptive and damaging effects on children of maltreatment and early inadequacies in the caregiving environment. Rather than seeing neurobiology, attachment theory, reflective functioning, and psychoanalytic psychotherapy as competing theories, I see them as using ideas which complement and support each other. The links between neurobiology, attachment, and psychoanalytic psychotherapy are explored in Green (2003), '*Emotional Development in Psychoanalysis, Attachment Theory and Neuroscience*'. Fonagy (2001: 84) in his book, '*Attachment Theory and Psychoanalysis*' has written of the meeting and divergence between these two theories. He points out that Bowlby's 'focus on the first year of life as a crucial determinant of later developmental outcome is, of course, highly compatible with the Kleinian approach'.

The work of Alvarez (1992) on psychoanalytic psychotherapy with autistic, borderline, deprived and abused children, brings together psychoanalytic concepts such as reverie and containment, and the reciprocal interaction between mother and child as described in child development research, greatly increasing our understanding of and ability to make contact with some of the most unreachable children.

Ideas which have been particularly helpful to me are disorganised attachment, rejection of care and nurture, projective identification, containment, and the trans-generational transmission of trauma. The idea of an 'unsolvable dilemma' (Main and Hesse, 1990), or 'fright without solution' (Hopkins, 2000), which 'disorganised' children experience, and which continues to affect them in new relationships, is crucial in attempting to understand and live and work with children like those in this study. These are typically the children who are referred to child psychotherapists. The ideas of Henry (1979) and Dozier (2002), of rejection of care and nurturing, and the establishment of 'crippling defences' (Henry, 1979: 33) are extremely helpful in trying to understand children like those in this study, and the defences against anxiety which are mobilised by both children and their carers.

I have found that psychoanalytic literature adds something more to our understanding of the nature of interactive relating by considering the unconscious processes which are constantly occurring in relationships. The concepts I have described here are of central importance to this study: projection and projective identification, as described by Klein (1946), Bion (1962) and Joseph (1987); containment (Bion, 1962); transference and countertransference (Freud, 1912 and Heimann, 1950), and how early experience is transferred and re-enacted in new relationships (Freud, 1912 and Fraiberg, 1975). Pozzi (1999: 52) refers to the ‘use of transference and countertransference, projections, understanding and containment of feelings, family dynamics, boundaries and family histories’ as being a key part of her work with under-fives and their parents.

Finally, a central idea to emerge from my reading and, as I will show, from the findings, is the importance of the emotional connection and the two-way interaction between a child and his caregiver (Balbernie, 2001; Siegel, 2001; Lieberman et al, 2005; and Music, 2011). Interventions which treat the relationship rather than the individual are now recognised in the evidence base as effective (Fraiberg, 1975; Hopkins, 1992; Pozzi, 1999; Baradon et al, 2005; and Lieberman and Van Horn, 2008).

3. RESEARCH METHODS

3.1 Qualitative Research

The central concern of qualitative research is the discovery of meaning and the attempt to understand how people make sense of the world and their experiences (Willig, 2001). McLeod (2001) describes the main source of knowing in qualitative inquiry as the researcher's engagement in a search for meaning and truth. It is an attempt to describe and explain experiences rather than to predict them. As this study involves the attempt to produce knowledge by learning about the experiences of carers who have looked after under-fives with an early history of neglect and abuse, I chose a qualitative research method as most apt to the purpose.

Qualitative researchers believe that it is not possible to gain objective knowledge about others' experiences, and that the researcher herself plays a role in knowledge generation, i.e. 'the researcher is central to the sense that is made' (Banister et al, 1994:2). Moving away from a realist position, which assumes that reality can be measured objectively, qualitative researchers take a constructivist and/or a hermeneutic position, with the belief that all reality is in some ways constructed (Midgley et al, 2009:7).

3.1.1 Qualitative Research and Child Psychotherapy

Child psychotherapists and qualitative researchers share something in common in their search for meaning and truth, and the attempt to understand an individual's experience. There is a long tradition within child psychotherapy of the single case study evaluation; however, there is increasing pressure to provide well-researched evidence of the effectiveness of child psychotherapy as a treatment method (Midgley et al, 2009:115). This poses a considerable challenge to child psychotherapy as traditional quantitative research methods tend not to sit comfortably with what is often considered the subjective search for meaning in psychoanalytic child psychotherapy. As Desmarais (2007) says, there is an 'uneasy relationship' between psychoanalysis and science.

I have chosen to research not a single case study of a piece of therapeutic work, but to interview carers about a specific situation. This takes me outside the realm of direct clinical work and into the area of exploring unconscious processes in settings other than the consulting room and the therapeutic relationship. Rustin (2006 and 2011) has written of the possibility of generating psychoanalytic knowledge from the setting of infant observation; the present study sets out to generate new knowledge from conducting interviews with carers with the specific experience of looking after an under-five who has experienced early neglect and abuse. Despite the fact that I was not part of a transference/countertransference relationship in the sense in which we think of it in the clinical situation, by interviewing carers I heard their account of a relationship which involved the unconscious mechanisms we are used to experiencing in a therapeutic relationship. Thus I witnessed these processes taking place in the caregiving situation as described by the carer.

As a child psychotherapist, I bring a psychoanalytic perspective to my analysis and interpretation of the interviews, and to the accounts of the circumstances which led to the breakdown of the placements.

3.1.2 Subjectivity and Reflexivity

Qualitative researchers believe that it is not possible for a researcher to adopt an entirely neutral or objective position, and that the researcher inevitably influences the process. Rather than this being seen as an obstacle, something which needs to be removed, qualitative researchers acknowledge the position of the researcher and her interaction with the material, and use this as information which is useful to the process (see Banister et al, 1994; Hollway and Jefferson, 2000; Desmarais, 2007). Hollway (2012: 24) writes of her dislike of the ‘quantification of human behaviour’ and her need to find a qualitative method which allows her to ask questions about experience and meaning, as well as using reflexivity to help understand data that are unavailable to consciousness (Elliot et al, 2011).

Drapeau (2002) outlines the debate which sees researchers at one end keeping subjectivity at a ‘near zero level’ by staying close to the text being analysed and, at the other end, making use of subjectivity and drawing on one’s own experience so as to better understand the subject of study. Drapeau suggests that researchers use all sorts of defence mechanisms including denial, repression, displacement, intellectualisation and projection. He suggests that those researchers wishing to make use of subjectivity should undertake a personal analysis; however, an alternative option is to engage in the process of reflexivity. This can take the form of personal reflexivity: examining one’s own values, experiences, interests and beliefs; and epistemological reflexivity: how has the research question defined and limited what can be ‘found’? How has the design of the study and the method of analysis ‘constructed’ the data and the findings? (see Willig, 2001).

3.2 Interpretative Phenomenological Analysis

The data was analysed using Interpretative Phenomenological Analysis (IPA). IPA is a relatively recent qualitative approach, developed in the 1990s within psychology and now more widely used by researchers in the human, health and social sciences. The majority of published studies are in the field of health psychology; however, more studies are being published every year, in areas such as identity, mental health and sexuality (Reid et al, 2005).

IPA is concerned with lived experience, with how people make sense of their personal experiences and with the meanings of those experiences. ‘IPA aims to capture and explore the meanings that participants assign to their experiences’ (Reid et al, 2005). IPA is particularly well suited to attempts to understand human experience and human relationships, with its emphasis on individual and emotional experience (Smith et al, 2009). Participants are regarded as being experts on their own experiences and emphasis is placed on the importance of telling their stories in their own words.

Smith et al (2009) cite three areas of thinking which provide the foundations for IPA: phenomenology, hermeneutics and idiography.

Husserl, the ‘father’ of phenomenology, wanted to understand how events appeared to consciousness in its broadest sense, including unconscious processes (Giorgi and Giorgi, 2008:26). Phenomenology ‘aims to capture as closely as possible the way in which the phenomenon is experienced within the context in which the experience takes place’ (Giorgi and Giorgi, 2008:28).

In phenomenology, it is believed that assumptions or theoretical leanings can be set aside or ‘bracketed’ (Fade, 2004:648, Giorgi and Giorgi, 2008:33), in order to build up a comprehensive description of the ‘thing itself’ (McLeod, 2001). However, IPA does not adhere to this strict reading of phenomenology; rather it attempts to gain insight into a particular phenomenon whilst acknowledging the researcher’s role in interpretation of that phenomenon.

The hermeneutic aspect of IPA concerns the theory of interpretation. An IPA study ‘accepts the impossibility of gaining direct access to research participants’ life worlds’ and ‘recognizes that such an exploration must necessarily implicate the researcher’s own view of the world as well as the nature of the interaction between researcher and participant’ (Willig, 2008:56). IPA is regarded as a joint analysis or collaboration between the researcher and the participant’s words. The researcher stays close to the participant’s words and it should be possible to trace back the results to the actual transcript. An IPA analysis is thus ‘a co-construction between participant and analyst in that it emerges from the analyst’s engagement with the data in the form of the participant’s account’ (Osborn and Smith, 1998:67).

In practice, this means that the researcher’s own ideas and interpretations are required to make sense of the respondent’s personal account (Smith, 2008:53). Osborn and Smith (2006:217) write: IPA ‘combines a dedication to understanding the lived experience of the participant with a recognition that to achieve such understanding requires interpretative work on the part of the researcher’ (see also Eatough and Smith, 2007:118).

The third key theoretical basis for IPA is idiography, concerned with the particular, and concentrating on a detailed analysis of a single case before moving onto generalisations (Smith et al, 2009:29).

The combination of these three areas: exploration of lived experience and what it means to individuals; interpretation; and detailed analysis, is what distinguishes IPA from other methodologies. It was this broad basis of understanding an individual's experience of a specific event, interpretation, and in-depth analysis of a small sample of cases which appealed to me as a methodology which could be used in a piece of research with a basis in psychoanalytic thinking.

3.3 Data Collection

3.3.1 Recruitment

The carers were recruited through Glasgow City Council's fostering agency. The only stipulations were that the breakdown had occurred within the last twelve months, that the child was under-five at the time and had a background of abuse and neglect.

I made contact with senior management of the City Council's Fostering Agency, who agreed for me to recruit participants from their agency. Carers were approached by their SSW who explained the purpose of the research to them and gave them an information sheet (Appendix 1). This was followed up with a phone call to those carers who had agreed to take part, with the opportunity to ask questions. When I had received the signed consent form (Appendix 2) I carried out the interview.

Initially, I wondered if carers would be reluctant to agree to be interviewed about such a sensitive subject, one which might arouse feelings of guilt and failure. In the event, there was no difficulty in recruiting participants and all of the carers said they found it to be a worthwhile experience.

The child's SW and the carer's SSW, at the time of the placement, were invited to participate in a separate interview. They were subject to the same ethical process as the carers, i.e. they could choose to accept or decline involvement in the research.

3.3.2 Sample Size

In keeping with the idiographic nature of IPA, I chose a small sample of carers to interview. Smith et al (2009) recommend between three and six participants for first time IPA researchers. The number of carer participants I recruited was six, which involved eighteen interviews including the SW and SSW. This was based on the number of participants my contact at the fostering agency provided, which was seven. One carer withdrew, as she was too busy, and I decided to interview the remaining six, rather than make a selection and exclude some. I felt that this number was small enough to do detailed, in-depth analysis, while also offering some limited opportunity for comparison and contrast.

3.3.3 Variables

There were a number of variables which should be taken into account, for example the age and gender of the child, the length of time spent in the index placement, previous experience of carers, number of other children in the placement, and length of time between the end of the placement and the research interview. Studies with human subjects inevitably involve a large number of variables. In order to obtain a random sample, I chose not to apply exclusion criteria, therefore there was no specification for length of time in placement, of other children being present in the placement or not, or of the previous experience of carers.

3.3.4 Recording of Data

I used a digital voice recorder to record the interviews (with permission) and then transcribed them in full, including pauses, coughs, laughs etc. For the interviews with carers, I also recorded my thoughts and impressions immediately afterwards using a process recording. The process of writing up a psychoanalytic session with a child, a carer, or a different kind of experience one has been involved in, is one of the methods used by psychotherapists, for reflection after the event, alone, and later with a supervisor. This method, although subjective in nature, provides an insight into the subtleties of what occurs in the here and now between analyst and patient, interviewer and interviewee, something which cannot be reproduced in the verbatim transcript of a voice recording. Qualitative researchers often use such personal reflections in their studies, by keeping notes in a research journal, for example.

3.3.5 The Setting

In an attempt to lessen any discomfort with the process, I allowed the participants to choose where the interview would take place, either in their home, their workplace, or in my office.

3.4 Sources of data

3.4.1 Interviews with Carers

This is at the heart of the research, providing an insight into the relationship between carers and child, what happened when the child was in their home, and how the carers felt about trying to care for this child.

3.4.2 Interviews with Social Workers

The SW holds information about the child's birth family and his early experiences; he or she is responsible for providing care and protection for the child. These interviews provided information about the child's background history, the SW's view of the placement and what they think went wrong, and information about the support they provided to the child and, indirectly, to the carers. I did not view SW files therefore these interviews are based on the SWs' knowledge and recall of the case.

3.4.3 Interviews with Supervising Social Workers

The SSW role is to provide support and guidance to carers. These interviews provided a picture of the carers and the child, the carers' experience, and the working relationship between them and the SSW; the SSW's view of the placement and what they think went wrong; and information about the support they provided to carers at the time.

By doing three interviews for each case, I gained a unique picture of the child and his life, possibly affording me a more rounded view of the child than anyone else involved with the child at the time.

See Appendix 3 for the interview schedules.

3.4.4 Semi-structured Interviews

Smith (2008) advises that semi-structured interviews are the best and most commonly used way of collecting data for an IPA study. The interview style I adopted was semi-structured and informal. This style of interview allows the interviewee to determine the shape of the interview. The advantage of this style of interview is that it tends to produce more data than would a completely standardised interview. Although this leaves it more open to interpretation and takes longer to analyse, it allows for deeper exploration of the respondent's experience, including areas of internal experience.

Hollway and Jefferson (2000) note the obstacles to gaining direct access to the interviewee's experience, and introduce the idea of a 'psychosocial subject' and the impossibility of knowing the subject's world except through the eyes of the researcher. Hollway and Jefferson developed 'Free Associative Narrative Interviewing' to allow for analysis and interpretation of the subject's unspoken, unconscious motivations. This approach takes into account defences against anxiety and recognises the importance of unconscious dynamics. It aims to 'elicit narratives based more on free associations than answers to structured questions' (Hollway, 2012: 27). These are ideas which influenced my own interviewing style.

3.4.5 Other sources of data

IPA studies often make use of data such as diaries. As carers keep a daily account of the children's activities in the form of a log I could have included this in my study.

However, due to the limitations of the study in terms of size and time, I decided not to include carer logs. This meant that I could make my main focus the interview with the carer.

3.5 Presentation of data

The data is presented in the form of six individual case studies in order to do justice to the rich material the interviews provided. I chose to write up each case separately to reflect each individual's experience, and in keeping with the case study tradition within child psychotherapy. It is also the favoured style of presenting data using IPA. The inclusion of direct quotes from the carers' interviews allowed me to tell the story of the placement breakdown from the carers' perspective.

3.6 Data analysis

Interviews were recorded and transcribed verbatim, as is usual for an IPA study using interviews. The interview transcripts were printed with two wide margins on either side; this is recommended for making notes in the margins. The process of listening again to the interviews, and typing them verbatim, allowed me to become familiar with the material and the interviewee's style, even before beginning the analysis. Using IPA to analyse a transcribed interview is a time consuming process. Only the carer interviews were subjected to this in-depth analysis.

The following is an outline of how I went through the printed interviews, moving from initial ideas, to the creation of more abstract concepts, and gathering these into themes (see Fade, 2004, Willig, 2001, and Smith et al, 2009):

- I read the transcript several times, to familiarise myself with the text; this is the initial encounter with the text.
- I went through the transcript again, and in one margin, made a note of anything that came to mind, or caught my attention; this is a process similar to free association. I did this at least twice to allow for full interaction with the text, and to see if anything different became apparent.

- At the next stage, I read through the initial notes made in the margin and formed these into more abstract concepts, which were written in the other margin. This stage involved close interaction with the data, as I moved between the interviewee's words and my initial notes to capture the essence of what the interviewee was saying by creating more abstract concepts, moving back and forth between the words of the respondent and the abstractions. This stage involves reducing the volume of detail whilst maintaining complexity, and 'an analytic shift to working primarily with the initial notes rather than the transcript itself' (Smith et al, 2009:91). (See Appendix 4.)
- Once I had gone through the entire text in this way, I moved to the stage of creating over-arching or 'super-ordinate' themes which captured the essence of what the carer was conveying. One suggested way of doing this is to lay out on a table, or pin up on a board, all the abstract concepts created from the initial noting, to look for connections between them and pull them together to form 'clusters'. These clusters then formed 'super-ordinate' themes. This can easily be linked to the raw data. (See Appendix 5.)
- Some themes had to be abandoned or excluded, as not being well represented within the text or because they were subsidiary to the main themes.
- I then wrote this up into a narrative account.
- The whole process was repeated for each case.
- Finally, I selected and grouped common themes across all six cases. This forms the basis of the discussion chapter.

3.7 Research ethics

3.7.1 Formal Ethical Approval

My proposal was submitted to the Research Ethics Department of Greater Glasgow and Clyde NHS, and I attended a formal meeting of the Committee to discuss the ethical issues relating to the proposed research. In the process of gaining formal ethical approval for my project, I learned about the importance of honesty, integrity and objectivity when undertaking any research. I also became aware of the need for transparency, and being clear and unambiguous about the nature of the research and participants' involvement in it. The need for impartiality was particularly important in this study, where I was interviewing three different people about one situation, some of whom had different views to each other about the subject being discussed, and where I became party to information which one of the three may not have been aware of.

Ethical approval was also received from the Head of Service of the Fostering Agency.

3.7.2 Consent

Participants received an information sheet with details of the purpose of the research, intended possible uses of the research, measures taken to ensure confidentiality and anonymity, and secure storage of data. Participants were made aware that, should anything of a child protection nature emerge from the interviews, then appropriate steps would be taken to address such issues.

Signed consent was received from all participants before the interview took place. I emphasised that participation was voluntary and that participants could withdraw at any time if they chose to do so. Consent is not necessarily a straightforward agreement to participate, particularly when the nature of the subject being explored is sensitive, personal and potentially upsetting. Hollway and Jefferson (2000) write of consent as an on-going process rather than a decision.

From my own clinical experience, I was aware that interviewees might enter areas which they had not expected to and that this might involve emotional distress. If this occurred, I indicated that I would contact the carer's SSW to offer support to the carer. I found that, in the event, in most of the interviews, carers did become upset, but that the interview itself was experienced as supportive, as a form of debriefing of the experience, and carers were grateful for the opportunity offered by the interview of in-depth discussion of the emotional experience they had endured. This happened also with one of the SWs and one of the SSWs.

In all of the interviews, I was left feeling that I had given something to the participants, rather than the other way around. This was possible because I approached the participants from a position of guarding against harm and created a safe context in which to explore the issue under question (Hollway and Jefferson, 2000).

3.7.3 Anonymity

All names and identifying features have been changed to ensure anonymity.

3.8 Reflections on methodology

There is some crossover between IPA and grounded theory, and aspects of social constructionist thinking and discourse analysis will be found in an IPA study.

Grounded theory is good for understanding social processes whereas IPA is more concerned with individual or personal experience (Willig, 2001:100). Smith et al (2009) acknowledges the similarities to grounded theory, noting that both have a broadly inductivist approach to inquiry. One of the main differences between the two approaches is that grounded theory aims to generate theory whereas with IPA theory emerges through analysis and interpretation.

Social constructionism is a ‘shared consciousness rather than a movement’ (Gergen, 1985:266). Social constructionist thinking is concerned with the historical, cultural and linguistic aspects of how people understand the world, and the idea that reality is constructed rather than being an objective truth which can be grasped. The idea is that there are ‘knowledges’ rather than ‘knowledge’ (Willig, 2001:7). Social constructionist thinking, then, shares some common areas of interest with IPA. For example, one of the ways suggested by Smith et al (2009), when approaching the analysis of the data, is to focus on different levels of the text e.g. descriptive, linguistic, and conceptual.

Like social constructionism, Foucauldian Discourse Analysis (FDA) is a post-modern philosophical movement, rather than a detailed method of how to analyse large chunks of data. FDA uses a social constructionist framework and is derived from Foucauld's conception of power relations and subjectivity (Frost et al, 2010). Like social constructionism, FDA has a primary focus on language and how it is used in everyday life to construct our social worlds (Chamberlian et al, 1997).

The process of analysing the data necessitated a close detailed analysis of the written text and the words on the page. It was a process which encouraged immersion in the subtleties and nuances of language as well as in any failures to produce language. The interaction at that point was between the researcher and the text. This led to a focus on the structural and linguistic aspects of the interviews, and the adoption of a deconstructionist position of taking the text apart to find meaning.

3.8.1 Advantages of IPA

IPA is best suited to a data collection method which invites participants to offer a 'rich, detailed, first-person account of their experiences' (Smith et al, 2009). It is also 'concerned with the micro analysis of individual experience, with the texture and nuance arising from the detailed exploration and presentation of actual slices of human life' (Smith et al, 2009:202).

With its emphasis on individual experience, using IPA to analyse the data allowed me to get closer to the subjective experience of the individual carer, and to the intense emotional experiences they were describing. Smith (2009:200) states that, 'alongside identity development, emotional experience is probably one of the strongest prevailing themes in the IPA literature'.

One of the reasons I chose IPA is that it provides clear and structured guidelines on how to analyse large amounts of data, at the same time allowing for flexibility. Smith and others (e.g. Willig, 2001) note that there is room for freedom and creativity within an IPA study and that the researcher can be flexible in their application of the guidelines.

The clear structure and guidelines, the creativity and flexibility, and the emphasis on interpretation, were the factors which led me to believe that using IPA would be a research method which would sit comfortably with a study being conducted by a researcher who is also a Child Psychotherapist.

3.8.2 Limitations of IPA

Willig (2001:63) pointed out that 'IPA relies upon the representational validity of language'. She argued that this is a barrier to understanding the lived experience of the participant as language is regarded as constructing reality rather than being a direct expression of it, and different people will describe their experience in different ways. This is a valid point which I discovered during the process of close interaction with transcribed text which involved a focus on words and language. I have therefore included comments and reflections, in some cases, on participants' use of language.

Willig also questions the suitability of participants' accounts of their experience, asking 'how successfully are participants able to communicate the rich texture of their experience' and 'how many people are able to use language in such a way as to capture the subtleties and nuances of their physical and emotional experiences'. Willig feels that this requirement for participants to give rich and detailed descriptions limits the applicability of the method, as there are inevitably some participants who cannot provide this. This was borne out in at least one of my interviews where the carer struggled to find words to express the more distressing experiences. However, analysis showed that this was indicative of the whole experience which was being conveyed, not just about limitations of carers' verbal account.

4. FINDINGS

4.1 Introduction

At start of placement, the children ranged in age from 4 months to 42 months. Length of time in the index placement ranged from 2 weeks to 3.6 years.

Time lapse between end of placement and the interview ranged from 6 weeks to 11 months. I did not specify a maximum period of time between the end of the placement and the interview. This meant that for some carers a much longer period of time had elapsed than for others. It was not part of this study to look at the relationship between an experience and how that experience is recalled, one month or nine months later.

Only one of the six children had no history of previous involvement with social services. The other five had a long history of social work involvement, including daily support which had generated no change. Five of the children had previously been registered on the Child Protection Register. Three children came straight from home to the placement, while three came from a previous placement. There was a degree of urgency to find a placement for all six. Two had injuries which no-one was taking responsibility for or knew how they had been caused; two were being accommodated from home on an emergency basis; and two were coming from placements where the carers had said the child had to be moved at once. Three out of the six had respite care during the index placement.

The initial plan for five of the cases was to aim for rehabilitation to birth family. Only in Case 1 was a decision made at the point of accommodation that the child would not be returning home. For the other five cases it took some time before a decision was made either that the child would not return home (2, 3, 5 and 6) or that the child could return to a member of birth family (4). Of the six cases, only one child returned to extended family.

Five of the children had significant developmental delay. Only in two cases (1 and 6) were carers made aware of this before the child's arrival. In all six cases, carers were taken by surprise at the extent of the child's delay.

Case 6 was the only one where there were no other foster children in the placement; this had been a deliberate choice as the child was deemed to need a placement with no other children. There were birth children living in the home in all cases except 5, although adult birth children and grandchildren were frequent visitors to the home. Only one child in this sample was placed with a sibling for some time during the index placement.

Length of interviews varied between 29 and 54 minutes (see Table 1). I did not have a time length in mind when I carried out the interviews; I proceeded through my interview schedule at the carers' pace. The two carers who were more obviously anxious (1 and 5) were the two shortest interviews. The one which discussed sexual behaviour of the child (4) was also fairly short, perhaps a reflection of how emotive a subject it was for both the carer and the researcher to discuss.

Length of interviews	Word Count
1. 29m 35s	5,573
2. 54m 24s	12,815
3. 54m 32s	16,048
4. 38m 31s	8,514
5. 35m 25s	7,990
6. 48m 00s	10,850

Table 1

Five of the carers were employed by Glasgow City Council. Only one set of carers were employed by a private Fostering Agency, purchased by Glasgow City Council.

Now follows the presentation of each Case. The Case presentations follow the same outline:

- A box giving details of the individual child. The box also includes the main reason for breakdown, as defined by carers. However, there was not always agreement between all three parties about the reason for breakdown; this will become apparent in the main text.

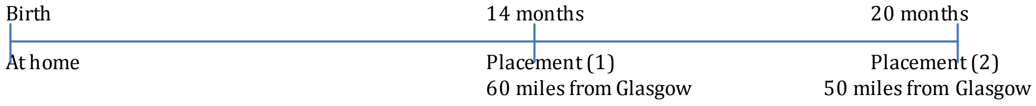
- A timeline of the child's life so far.
- Genograms: 1 – the child's family of origin; 2 – in the home at the time of child's placement; 3 – in the mind of the carers (only in cases 1, 3 and 5), represented by shading, to give a visual representation of what was in the carers' mind.
- The SW interview, providing background information and reasons for the child being accommodated.
- The carer interview, which is organised around the headings which represent the main themes from the data analysis. There is then a section on 'Process of the interview' in order to look closely at the how rather than the what – process rather than content.
- SSW interview. This is presented as a summary in most cases, to provide supporting information to the main themes.
- A section on Support.
- Reflections. There is a brief reflections section at the end of each case presentation.

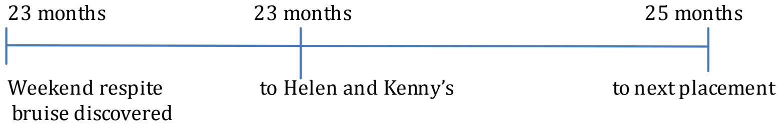
4.2 CASE ONE: ALISTAIR

Carers: **Helen and Kenny**
Child: **Alistair**
Age at time of placement: **23 months**
Length of placement: **8 weeks**
Who interviewed: Helen and Kenny (child Polly, age 10 months, also present)
Where interviewed: Carers' home
Time lapse between end of placement and interview: **6 months**
SW: **Ann**
SSW: **Joyce**
Reason for breakdown: Risk to other child

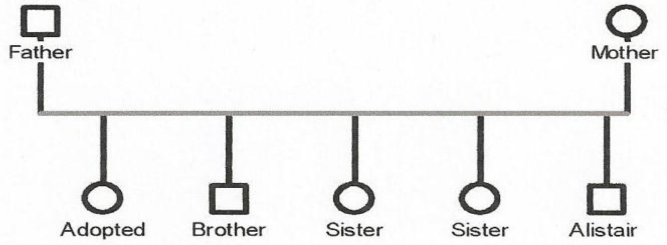
Box 1

Timeline

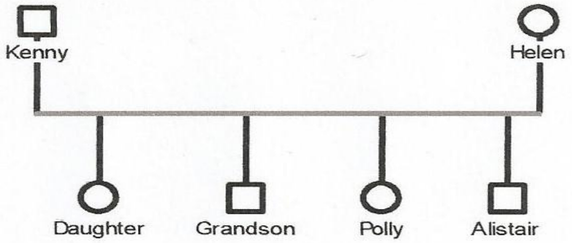




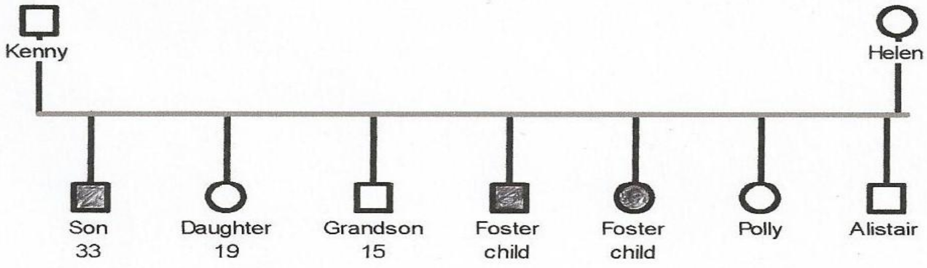
Genogram 1: Alistair's family of origin



Genogram 2: In carers' house at time of Alistair's placement



Genogram 3: In the mind of carers



4.2.1 Social Worker Interview

Background

Alistair was the youngest of four children. Both parents were described as having a learning disability. Home Support and Day Care had been attending the home four times daily, but this had had little effect on the parenting capacity of Alistair's parents, who were described by Ann as '*limited*' and unable to absorb the advice and guidance on parenting which was being given to them. There was a significant lack of parental care and neglect, with the children having accidents '*all the time*'. Ann said that Alistair's mother '*absolutely loved her babies to bits, you know, but she's no understanding of how to cope with them*'.

The household was described as loud with lots of shouting and screaming. The children had been on the Child Protection Register under the categories of neglect and physical abuse. The children were accommodated by a Children's Hearing. Due to the level of support the family had been receiving, it was decided from the outset that there would be no rehabilitation plan and the children would not return home. A community care assessment concluded that Alistair's mother did not have the ability to parent the children.

Ann's impressions of Alistair were that '*he was a poor wee soul*'. He looked dirty, needed glasses and cried constantly. All the children were dressed inappropriately for cold, wet weather, had no socks on and ill-fitting shoes. Ann knew that Alistair had often been strapped into a buggy in front of the television. When Alistair arrived at his first foster care home, he could not walk or talk: *'he wasn't walking, he was just kinda rolling about*'. Ann described a '*terrible hiss, he almost hissed like a snake*'; apart from this, he screamed.

Placements

The first placement Alistair had was described by Ann as '*fantastic*' with an attentive and skilled carer who helped Alistair to progress significantly. Alistair was placed on his own here, in a town at some distance from Glasgow, while two of his siblings were placed together in a home nearby and they saw each other almost daily. Unfortunately, the carer was diagnosed with a terminal illness and had to give up fostering, which meant that Alistair had to move.

His second placement was in yet another town at some distance from Glasgow. Apparently, these carers were committed to Alistair and wanted to keep him. However, when they went away for a pre-planned weekend and Alistair was in respite care with another set of carers, a bruise was discovered on his testicles. Neither set of carers knew how this bruise had been caused. Alistair had to be accommodated elsewhere while this was investigated. The conclusion was that the injury could have been accidental. Ann and other colleagues assumed that it had been caused by him jumping up and down on a rocking horse, but she acknowledged that this was only an assumption.

Alistair was moved directly from the hospital back to Glasgow, a journey of approximately two hours. Ann did not know where she was taking him, only receiving this information during the journey to Glasgow, which was late at night. She wrongly assumed that Helen and Kenny's SSW would give them information, due to the sharing of information between departments, available through their computer systems.

Ann commented on how easily Alistair appeared to settle at Helen and Kenny's. She said:

> *that worried me quite a bit because I thought, what have we done to this poor kid, he'll just go with anybody?*

She thought she had visited him two or three times during the eight weeks[5]. When she saw him she thought he was '*absolutely fine*'. Ann was aware of Alistair's developmental delay, and felt that he needed to be thought of as a younger child – more like a baby than a two-year-old.

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[5] SWs are required to visit a child in foster care once every four weeks.

When I asked about her relationship with Helen and Kenny she thought that she didn't really have a relationship as Alistair's time there was so short. However, she felt uneasy about the carers' commitment to the placement as Helen and Kenny said they could not transport him to contact and were insisting upon a nursery placement. '*I kinda thought that he was there as an afterthought*' she said. As the interview progressed, she became more confident in expressing her dissatisfaction with the placement. While acknowledging that she had no complaints about Helen and Kenny's level of physical care, she expressed doubts about their emotional availability and commitment to Alistair. She wondered why the carers were allowing him to watch TV all day and not interacting with him. She said, '*the baby* (i.e. Polly) *always seemed to be the priority*'.

Despite having said initially that he settled easily, she now said that he didn't settle as well with Helen and Kenny as he had in the first two placements:

> *he almost seemed to be on the outskirts of the family, and to me it was almost like – without the neglect bit – it was almost like being back at home.*

Ann admitted that she was surprised when the placement ended. She knew that Helen and Kenny wanted a nursery placement to ease the situation, but she was not aware of the '*barrage*' of issues which she then received in an email from Joyce. She was upset about the breakdown and felt that Alistair was being blamed for hurting Polly.

Ann, like Joyce, mentioned the loss of two previous children who had been adopted, and how upset Helen and Kenny were about it. Ann said that Helen and Kenny '*were probably still grieving for them*'.

At the end of the interview, reflecting on the unfortunate series of events, we noted that Alistair is on his fifth mother-figure now.

4.2.2 Carer Interview

Introduction

This carer interview was one of the shortest of the series, in length of time and word count, and contained many silences, hesitations and pauses. The data analysis produced themes relating to the carers' struggle to understand Alistair and to express this in words.

Positive, rewarding feelings

Near the start of the interview, as though to assure me that they were good carers, Helen told me of a previous successful placement, which lasted for four years and did not break down. Naturally enough, they wished to validate themselves to me as successful carers, not carers who give up on children. However, this also reflects the kind of positive state of mind they wish to have when starting out with a new child, the confidence that comes from experience and knowing what you are doing.

Feelings of pride and achievement were conveyed when they told me about something they had shared with Alistair, and that Kenny felt he'd given to him:

> Kenny: *I mean he could be a fun wee boy, I mean I'd sit here with him and watch cartoons*
> Helen: *uhu, uhu,*
> Kenny: *and a bit of a carry on, you know, putting the cowboys on.*
> Helen: *the cowboys,*
> Kenny: *and that'd be him,*
> Helen: *he used to sit and 'yeeha!'* (laughs)
> Researcher: *he liked the cowboys?*
> Kenny: *well I taught him that one* (laughs heartily) (Helen laughs too).

Such moments give carers a sense of achievement and the confidence to continue. These are also the kinds of memories which we hope the child shares and takes away as a good memory of his experience of the placement.

Not surprisingly in a situation which ultimately led to placement breakdown, feelings of fear, confusion and bewilderment, sadness and loss, far outweighed feelings of achievement and pleasure.

'The Fear Factor'

'Fright of my life', 'panic', 'hysterical', these are the kinds of words and phrases used in descriptions of how the carers felt and how Alistair appeared to them. All of these phrases were used in the following extract, when I asked them about how Alistair's screaming at bath-time made them feel:

> Helen*: I got the fright of my life the first time it happened. I thought, really there's something wrong with him.*
> Researcher*: mmmn hmmmn*
> Helen*: cos he was hysterical, absolutely hysterical.*
> Kenny*: and then, bring him out, he'd settle down,*
> Helen*: uhu.*
> Kenny*: see as soon as you brought him in, you were drying him, he was…*
> Researcher*: he was fine,*
> Kenny*: he was fine. The fear factor was away, you know what I mean, so he calmed right down again.*

This was the second time Helen used the phrase '*the fright of my life'*. Kenny held onto the fact that Alistair calmed down, but Helen recalled his hysteria. It was so terrifying to her that she thinks there's '*something wrong with him*'.

Helen occasionally adopted a practical, no-nonsense approach, one that doesn't allow space for thinking about Alistair's fears and anxieties. For example, Helen said that, at first, Alistair didn't like going to his bed. She said:

> *I'd go in again and I'd say, 'look Alistair, this is bedtime and it's time to sleep. Good night and I will see you in the morning. No more noise*'.

She wished that her firm words would make his fears and anxieties disappear, and, in turn, hers. However, she then acknowledged the difficulty in getting '*from there to* *there*' (the distance from his bed to the door) and called this '*the in-between bit*'. Helen began to think here and opened up a potential space for thinking, in this 'space in-between'.

When talking about Alistair screaming, which in turn caused Polly to scream, Helen described her own feeling of being overwhelmed: '*he's screaming there and she's screaming here and...*' With a few words, she gave a vivid description of the experience of feeling surrounded by screaming and not knowing which way to turn.

When describing what it was like when Alistair '*kicked off*', Helen said that it '*terrified*' the other child, emphasising the word to illustrate to me just how terrifying it was. Polly was '*really frightened*' and she would scream too. She described her own fear and terror when she said, '*I got the fright of my life*', and when she spoke of her own '*panic*' at the possibility of Polly being hurt:

> *But* (three seconds silence) *no, I just, I think I started to panic, the more it was happening. If she was going to get injured or whatever, you know.*

The Injury

The fear and uncertainty which permeated the placement was exemplified by the injury. Alistair was brought directly from hospital to the placement, with no-one having any knowledge of how the injury had been caused. There was a kind of hush around the subject, with fearful thoughts around what might have caused the injury. The carers had many questions about it – how had it been caused? Who caused it? Would they be in trouble if they spoke about it due to the legal process? Was there an unspoken fear that they were under suspicion too?

It was a mystery which surrounded Alistair, adding to the sense of not knowing about him with which the carers were confronted. It was given another layer of mystery by the way in which the carers spoke about Alistair being injured '*down below*'. It was me who put into words that this meant his genitals. This led to a silence of four seconds and Kenny turning away to talk quietly to Polly, as though frightening and potentially painful thoughts and feelings have to be turned away from.

Predictability and unpredictability

Helen and Kenny moved between a state of mind of predictability – '*you knew it was coming*' - and unpredictability – '*you just never knew the minute*'. The former phrase suggests bracing oneself against something challenging, while the latter suggests how precarious things felt, that they could be taken by surprise at any moment. This, in combination with the lack of information and knowledge about Alistair, led to a state of constant tension and not being able to relax or feel comfortable with him. Kenny gave a noteworthy description of how disabled they felt by not having any knowledge or information, when he said '*you're working blind*'. This implies a significant disability, of groping around in the dark and feeling that you don't have the use of one of your major senses – sight.

Unfathomable

Helen said that one of the things she found difficult was Alistair's fussiness around food:

> *That was a puzzle to me, the food situation I just, I couldn't grasp. He would eat a sandwich and cheese but not a sandwich and meat* (followed by two seconds silence).

Later, when talking about his dislike of certain textures in his mouth, she said she couldn't '*fathom*' that. The word captures the depth of their experience, and the feelings aroused by their attempts to understand Alistair, not just in the area of food. It seemed profound, immeasurable, incomprehensible, unknowable, and inexplicable. Kenny backed Helen up, saying '*no idea where that came from*'.

Towards the end of the interview, when Helen was talking again about the problems with feeding, she said:

> *If you give him something he liked, he would eat and eat and eat but, you know, just getting him to have, like, different things and introduce different things to him was…*

This short passage highlights Helen's struggle to fulfil one of her basic tasks as a carer. The description led me to think that Alistair, if permitted, would gorge himself on foods he liked, not an uncommon by-product of emotional and physical neglect. Ann told me that he would gorge himself until he was sick. The way in which Helen drifted off, not expressing in words how she felt about his rejection of her attempts to introduce him to new textures and flavours, gives an insight into the ways in which Helen felt rejected, and the hopelessness she felt.

The idea of Keats' 'Negative Capability' came to mind in this case, and the capacity to be 'in mysteries, uncertainties and doubts without irritably reaching after fact and reason' (Keats, 1817). Helen and Kenny were surrounded by 'mysteries, uncertainties and doubts'.

Sadness and Loss

Some regret at the situation was expressed by Kenny when he reflected, rather sadly, that they didn't have the time to work on areas of developmental need with Alistair. Helen, too, seemed regretful when she said that Alistair was '*a lovely wee boy, and just wanted love. He really did.*' While this could be seen as an idealistic view of what Alistair needed, Helen seemed aware that something got in the way of that love being provided to him.

The real sadness at the loss of the two previous children was revealed only after I had switched off the DVR, at which point both Helen and Kenny continued to talk, more freely than when it had been on, and they quickly got onto the subject of the two children who had been adopted some months before. In fact, Helen became tearful and I realised that her mind was still filled with these other children.

Unconscious expression of feelings of guilt and failure

During this interview, there was an aside, when Helen had Polly on her lap, bouncing her gently up and down in an attempt to settle her. '*I'm going to throw you out. I'm going to throw you out*', she sang to her, jokingly. I felt completely taken aback at these words appearing in an interview, the focus of which was to explore the carers' experience of a previous placement which had broken down, and in which, frankly, the child was 'thrown out'. I felt as though all the defences the carer had erected against her feelings of guilt and failure were expressed in this apparently jokey comment to the other child. This was the only interview in which there was no direct expression of guilt; but the comment – '*I'm going to throw you out'* – if taken as an unconscious communication, suggests Helen may have felt enormously guilty about ending the placement.

Living with Conflicting Feelings

The Data Analysis highlighted the close connection between the emotional impact of looking after the child and the struggle to put this into words (discussed in Section 6.2.3). It also showed the number of conflicting feelings Helen and Kenny experienced and had to struggle with. I have brought these together in **Table 2**, using words taken from my data analysis, to illustrate the simultaneous existence of opposing feelings.

This experience seems to have led to feelings of panic, of not being in control or attempting to take control, and living in fear of what might happen next. This is suggestive of the kinds of state of mind experienced in disorganised attachment. These feelings could equally be assigned to Alistair, a clear illustration of the way in which such feelings were projected back and forth between carer and child, child and carer.

Confidence Previous success	Confidence undermined
Knowing something	Uncertainty Lack of information Disabled ‘Working blind’ Not knowing/defences against not knowing
Good clear description	Puzzled, bewildered Beyond words Feelings in gasps and silences Struggling to express something Something not expressed/holding back
Explanation	Searching for an explanation Inexplicability Beyond help or understanding Physical vs. psychological explanation
Thinking, feeling and reflecting	Avoiding thinking and feeling
Empathy Pride Achievement	Feeling overwhelmed Consumed by distress Disillusionment/disenchantment Avoidance of feelings of distress

Table 2

4.2.3 Process of the interview

Not surprisingly, given the emotive nature of the subject under discussion, the carers’ communication was far from straightforward. At times, communication of their experience was clear while at other times there was an absence of clear description; at yet other times there was a departure from the issue at hand and the carers ended up talking about something else.

This interview is more complicated because there were two carers being interviewed. Their style of talking was to talk together, sometimes completing each other’s sentences, looking to each other for agreement, very much a complementary communication. This was also noted by Joyce, who said, '*they finish each other's sentences and talk over each other*'.

Beyond Words

In the interview with Helen and Kenny, there were lots of 'I don't knows', and what felt like a difficulty in getting going, with many of my questions not leading to a full or flowing account. This could be seen in answers like '*no, it was…whatever*' and '*whatever, you know, I don't know, just…*', and in the silences which often interrupted any dialogue or flow of speech.

It was as though it was beyond words to describe or explain their experience, or not possible to use their previous experience, although they had looked after twelve children prior to the start of Alistair's placement. It seemed that Alistair's ways did not fit into their existing knowledge of how children should be; they were thrown off course, puzzled, baffled and silenced.

Struggle to express something

When I asked about their first impressions of Alistair:

> Kenny*: mmmn, ah, nothing…he could hardly, he could barely walk, that was my first thought is, oh he's struggling walking but, eh, no, nothing.*
> Helen*: I mean he wasn't shy, he come over to us,*
> Kenny*: (quietly) nothing stuck out as such,*
> Helen*: and we spoke to him and, at that particular time nothing,*
> Kenny*: nothing jumped out as such.*
> Helen*: no. Just apart from his legs, was all over the place.*

Their reply contained the word 'nothing' five times, giving the impression that here is a boy with nothing remarkable to comment on, other than that he can't walk very well. This set the tone of the interview, in which it felt difficult to get a flowing dialogue.

This initial '*nothing*', however, led onto four facts: his legs were '*all over the place'*; his shoes were too small for him; he'd just had a long journey from another city in Scotland; and he was injured '*down below'*. It is notable that the carers turned to factual or practical reasons to explain his poor walking: the injury, his shoes being too small. They didn't assign any emotional connection to his delay in walking, and the neglect is only hinted at.

I asked the carers to tell me what they meant by Alistair '*kicking off'*. Helen's immediate response to this was to make a sound – '*whof*' – which expressed to me how extreme this '*kicking off*' was and how difficult to articulate it. A moment or two later, however, Helen was able to find words and gestures and gave a very clear account of what this was like:

> *like a high pitched scream and just uncontrollable, constantly hands and arms* (moving her arms up and down in a flapping motion to demonstrate) *and high pitched scream.*

In this instance, she was able to move from the inarticulate to the articulate (although, arguably, '*whof*' is a very expressive communication and carries meaning).

Moving away from feelings of distress

When I asked Helen to describe what sort of things made Alistair laugh, this led to what I noted as a possible shift in meaning. Helen said that '*he loved attention*', adding that he couldn't be left by himself for a moment:

> Helen*: he didn't want to be in here by himself.*
> Researcher*: so, if your attention was somewhere else…?*
> Helen*: so would he be* (laughs).

Helen had started out with a positive description of Alistair who '*loved to laugh'* and liked playing on the floor with toys, and drawing. But Alistair could not remain playing or drawing if Helen left the room and would follow her wherever she went. Helen laughed about this but then fell silent, as though it was too painful to articulate what this points to, that Alistair lacked confidence and security and was searching for a reliable, secure base.

When I tried to hear more about the '*high pitched screaming'* Helen described, Kenny moved us away from this to another problem, namely, Alistair's poor coordination and risk of falling on the baby. This was a shift away from their own experience of trying to tolerate and understand a screaming child, to thinking about the risk to the baby.

Later, when I asked them to describe Alistair's personality, Helen shifted from a description of Alistair to a complaint about social work:

> *He loved to laugh, uhu. Yes, he had a* (pause) *a smashing wee boy just…* (pause, apparently struggling to find the right words) *he loved* (pause) *other children as well, to play with, like my grandson. He loved when he came up and he played great with him. From day one, they did say that he would get a nursery placement, and they never ever got a placement, whether they tried hard enough or not I don't know, but eh, that would've really benefited him.*

She began falteringly, and then warmed up with a possible complaint that the SW did not find him a nursery placement although she had said she would. As soon as Helen thinks of Alistair as a '*smashing wee boy'* who enjoyed playing with other children, anger appears that he didn't get enough of this, or didn't get what she felt would have benefited him. Her anger and guilt about having had to end the placement become mixed up with feelings of resentment towards social work that they did not organise a nursery placement. She sees it as a lost opportunity and a factor in the breakdown.

When I asked how they felt about Alistair coming, Helen's quick reply was *'I was quite happy about it*'. Kenny agreed, '*no problem*'. Helen then spontaneously gave her thoughts about Alistair:

> Helen*: he was a lovely wee boy, and just wanted love. He really did. And I think* (gasps, short exhalation of breath) *maybe with Polly being here as well, he felt a wee bit threatened because he was always used to being the baby in the family.*
> Researcher*: yeah*
> Helen*: Yes. Uhu.*
> (Seven-second silence.)

We see how reflecting on how Alistair might be feeling leads to an interruption, here a seven-second silence.

There were many silent pauses or moments where the carers didn't finish a sentence and just drifted off (indicated by three dots…). This extract followed my asking them if they knew why Alistair had been accommodated. Kenny had said he thought '*there was maybe an abuse*' and I asked if he knew what kind of abuse:

> Kenny: *Don't…I don't know if…I might be wrong with the abuse, I remember there was an incident, I'm sure there was an incident with one of the grans.*
> Helen*: Yes*
> Kenny*: eh…*
> Helen*: something about the gran in a caravan, she was drunk or something.*
> Kenny*:* (coming in) *in a caravan, she was drunk, and whatever happened…*
> Helen*: she just sorta flipped and…*
> Kenny*: and how the social work got to hear about it, I don't know the ins and outs of it all.*

Their answer is vague and uncertain; they are not sure how Alistair came to be accommodated. On a practical level, this is linked to the lack of information they received about Alistair before he arrived, and even after he arrived, they still did not receive much information. However, it is also indicative of a reluctance to dwell for too long on Alistair's experiences of abuse and neglect.

4.2.4 SSW Interview

Joyce was a social worker with many years of experience. She had been working with Helen and Kenny for only a short time before Alistair was placed with them. She had not been working with them when they had the two siblings who had recently gone for adoption, but was quickly aware of how upset they both were at the loss of the two children, telling me within the first two minutes of the interview that they were '*traumatised at the loss of those two children*' and '*just how near the surface that pain still was*'. She spoke about the other child, already in placement, Polly, referring to her as '*the love of her life*' (Helen's life) and how upset both carers would be when she moved on.

They received scant information about Alistair. They were told that he screamed and that he didn't like the bath, but they did not know why and did not know of any triggers for the screaming. In contrast to the carers, Joyce was eloquent in her descriptions of Alistair's distress and screaming. However, she readily admitted that she had '*no understanding of why he started screaming*'. Due to the investigation into the previous carers and the respite carers, they were not allowed to speak with them to get information. Joyce noted that she would usually arrange for her carers to speak directly with the previous carers to get detailed information about a child's preferences and so on, but that this was not possible due to the on-going legal process. She was clear that having prior information is '*absolutely crucial*'.

Joyce was unclear about whether or not there was an organic or global developmental disorder. She had been informed that '*he had a habit of bumping into things*' but knew little more than this. She thought Alistair had been investigated for Fragile X and that it had been ruled out. She described Alistair as having a '*slightly odd appearance*'. He wore glasses, which he regularly broke. Joyce said that he arrived with several pairs of glasses but they didn't know which ones he should be wearing.

Joyce spoke about the injury and not knowing how it had been caused. She assumed that it had been caused by another person but was never informed who or what in fact had caused it. She noted that Alistair was '*neither up nor down*' on moving to Helen and Kenny's. She also noted that the first time she met him he came over to her with arms open, which she recognised is '*never a good sign…to approach a stranger with your arms open*'.

Joyce spoke of the carers' '*high tolerance*' for babies with neonatal abstinence, their screaming, being able to feed them and get calories into them, '*but they couldn't, they couldn't manage Alistair*'. She thought this may have been because he was mobile. Joyce thought that Helen was '*traumatised by the screaming and worn down by the feeding*', and named the screaming as the most distressing behaviour. She said that both Helen and Polly got upset at Alistair's screaming but she didn't know which came first. She wondered if it was Helen getting upset and '*agitated*' and hence Polly becoming so too, or was it the other way around? She felt that the situation '*became a trauma rather than a challenge*'.

Joyce felt that being able to say that Alistair's presence was having a detrimental effect on Polly was easier for Helen and Kenny; she felt it gave them a '*get-out clause*': '*Alistair's upsetting Polly, therefore Alistair has to go*'. Joyce thought that Helen felt guilty about bringing the placement to an end.

Joyce thought that there was a noticeable difference in Helen's manner with Polly and with Alistair:

> *she was altogether more loving with Polly; with Alistair there was an element of duty in it.*

She called the carers '*warm and caring people*' but felt that the

> *emotional warmth and acceptance and…* (searching for words) *that wasn't- that hadn't developed.*

Joyce spoke about the importance of knowing your carers, and being able to judge if they have the capacity to '*stretch*' and get through difficulties, '*or whether you're actually just asking for trouble to ask them to stretch*'.

Her immediate answer to my question, '*did anything make your task more difficult*?' was '*my lack of relationship with Helen and Kenny*'. She said this is like '*operating in the dark*', echoing Kenny's words describing their situation, '*you're working blind*'.

4.2.5 Support

- The idea of the importance of support was absent from this interview, and Helen and Kenny had little expectation of receiving emotional support required for their task. Helen made passing reference to having received few visits from Ann, but she did not openly criticise this. Very little reference was made to their own SSW, Joyce.
- Ann received support from her Team Leader and knew how to access support and help. She confessed that she was '*quite upset*' after the breakdown, thinking '*this is my wee boy that's had to move again*'.
- Joyce hoped that she had been supportive to Helen and Kenny, but she noted that she '*didn't have the depth of knowledge of them that would have been helpful*'. Joyce did not comment on her experience of support from her own organization.

4.2.6 Reflections

This case highlighted the difficulties in giving voice to the emotional experience of trying to care for Alistair, and a reluctance to dwell on thoughts which might be painful, uncomfortable, and anxiety-provoking. The knotty communication, and silences and unfinished sentences, are indications of feelings which were painful for the carers to access and to express.

Helen was anxious before the interview started, while we were waiting for Kenny to arrive. She said to me that she hoped it would not be '*too in-depth*'. Although I discussed this with her before the interview began, and assured her that she did not have to answer any question she felt uncomfortable with, her comment may have affected me by making me feel wary, particularly as it was the first interview I had conducted. I was not yet comfortable in the role of interviewer/researcher. Equally, however, it could be an indication of Helen's anxiety that it was something about her, rather than Alistair, which had contributed to the breakdown.

My probes were often fruitless, unproductive and did not lead anywhere. They did not bring the desired further information, or a meaningful reciprocal dialogue, or speculating and wondering what might be going on for Alistair. It was a blind alley, like the idea of '*working blind*' which Kenny described. This reflected what happened in their relationship with Alistair, a struggle to understand each other and a difficulty in establishing a meaningful two-way interaction.

Helen's request that it not be 'too in-depth' may have been another way of saying, 'don't ask me to think too deeply about things'. Giving more thought to the situation might lead to thoughts about:

- Helen's relationship with Alistair and her role in the breakdown. A fear that it's her 'fault' that the child was so distressed (identification with maltreating parent).
- What might be interpreted as inadequacies of caregiving and a failure to understand and connect with the child.
- Why Alistair might be as he is – because of early neglect and abuse (reluctance to make a link with Alistair's history of maltreatment).

In the absence of a space for thinking and understanding, the carers were more vulnerable to the force of the child's projections. The child's terror became lodged in them and they were unable to tolerate it. They had nowhere to process or understand it. Rather than being able to think about Alistair's distress and screaming as something he needed to communicate, and which they might be able to help him with, they felt they had to erect strong defences to protect themselves against such pain and anxiety. This is an example of the excessive use of projective identification leading to a failure in the carers' capacity to act as a container for the child's projections (Rosenfeld, 1987 and Joseph, 1987).

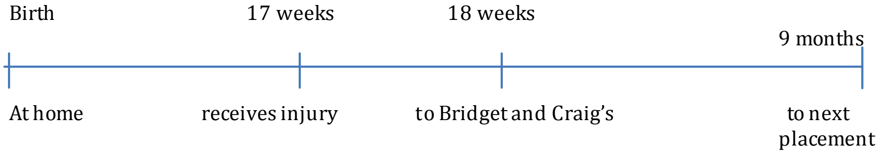
It should be recalled that this came in the context of the loss of two previous children, acknowledged by everyone in this case as being a source of sorrow for these carers. The child, too, had just lost two sets of carers, as well as his birth parents. This perhaps left them feeling vulnerable and less resilient, less well able to withstand the powerful feelings which were aroused, and less able to access what each might have to offer the other.

4.3 CASE TWO: MOHAMMED

Carers: **Bridget and Craig**
Child: **Mohammed**
Age at time of placement: **18 weeks**
Length of placement: **5 months**
Who interviewed: Bridget
Where interviewed: Carers' home
Time lapse between end
of placement and interview: 12 weeks
SW: **Fiona**
SSW: **Brenda**
Reason for breakdown: Not sleeping

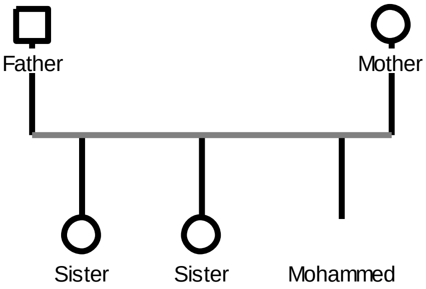
Box 2

Timeline

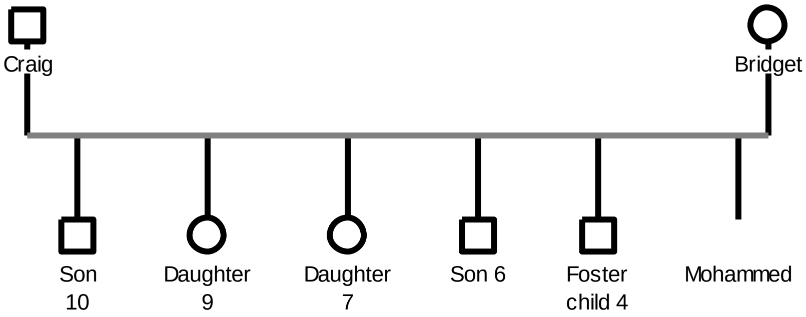


Genograms

Genogram 1: Mohammed’s family of origin



Genogram 2: In carers’ house at time of Mohammed’s placement



4.3.1 Social Worker Interview

Background

Fiona was allocated this case after Mohammed had been placed with Bridget and Craig as her predecessor had gone on long-term sick leave. She inherited a case in which there were serious injuries to a child with nobody taking responsibility for them, and with eight different adults from the extended family who could have been responsible. She also inherited a case in which difficulties within the placement were already being expressed, as Mohammed was not sleeping and Bridget was finding it difficult to cope.

Mohammed was the youngest of three children and, while his older siblings went to live with other family members, he was accommodated because his parents declared that they had no idea how the injuries had happened. They had also failed to take Mohammed to hospital for several days. He had five breaks in his arms and there was uncertainty around whether these had been caused in a one-off incident or if there had been more than one incident. The police were involved but, after several months, they concluded that they did not have enough evidence to bring charges. At the time of Fiona's interview, there was still no resolution and the case was due to be heard in the Sheriff Court, to establish the grounds to keep Mohammed in foster care, but this was not scheduled to take place for another four months.

This was the only case in which the child was not already known to social services. The first time he came to their attention was when the family presented at the hospital with Mohammed's fractured arm. This was clear from Fiona's comment, '*they were completely unknown to us*' and her repetition of '*nothing – we knew nothing about this family*'.

Placement

Fiona commented on how difficult it was to hold in mind two opposing views of Mohammed's parents:

> Fiona*: cos you kind of have – two sides. But, you know, you have, on one hand you look at them and they're* ***really***

> *good on contact, they're responsive, they're caring, they're affectionate, they can manage the three kids, they work well together, they've done everything we've asked of them,*
> Researcher*: mmmn hmmmn*
> Fiona*: and on the other side you have this baby with five breaks, and i- i- it's how you marry those two bits together is really* (takes a breath in) *difficult,*

She described being '*in limbo*' until they could get a resolution to the situation.

Fiona did not know or have any ideas about what could be causing the no sleeping; birth parents said that it had not been a problem for them. She was left feeling puzzled about this, particularly as it stopped being a problem when Mohammed moved to the next placement.

Fiona's account of events matched Bridget's account, except for the matter of respite, which Fiona believed to have been put in place. This differed from Bridget's account, as she said that respite was not organised regularly.

Although Fiona was aware of how exhausted Bridget was, and that not getting any sleep was a significant issue, she was surprised at how quickly the placement came to an end when it did: '*she just pulled the plug on it*', '*it happened faster than I thought*', and '*I wasn't expecting her to give us an ultimatum like that*'. This mirrors how it must have felt to Mohammed when he was suddenly moved to a different foster home; it also indicates a failure in communication, either in imparting or in hearing information, that Bridget reached breaking point without Fiona realising that the situation was so desperate.

Her feelings about the sudden ending were further complicated by her positive view of the care provided by Bridget: '*we had no concerns*', '*she was clearly very fond of him*' and '*he was very comfortable in her care*'. Fiona was aware that Bridget went above and beyond her expected duties, acknowledging that Bridget cooperated with the rehabilitation plan, taking Mohammed to contact three times a week, which she knew that not all carers would have agreed to do.

She became self-accusatory in her reflections, saying that perhaps they should have intervened earlier to recognise that the placement was in difficulty and asking the question more clearly, '*is this the right placement?*'

She questioned and criticised the systems and practice of her organisation, suggesting that there is often a feeling of relief when a placement is found rather than thinking about getting the right placement for the child: '*not just, thank God we've got a placement*'. This relief at having found a placement somehow over-rides or lessens the wish to find the right placement which suits both carer and child.

4.3.2 Carer Interview

Introduction

Of the six cases, this case stood out from the others as being quite different, not obviously falling into the category of a child coming from a long history of neglect and abuse. Mohammed was also by far the youngest child of the six – only four months old when he was accommodated.

'Unexplained Injuries'

This was the reply Bridget gave when I asked what were the reasons for Mohammed being accommodated. It was brief and to the point: '*unexplained injuries*'. The phrase itself brings up frightening and disturbing thoughts and questions: who caused the injuries? How are they to be explained? Will someone be charged and prosecuted for serious harm to a child? What has this child suffered? I felt appalled on hearing the description of his injuries, and the fact that healed fractures were found on his other arm at the hospital. As Bridget explained, it was not clear if the injuries on both arms had happened at the same time, or if some had happened earlier and had healed, that they had been less severe and so healed more quickly. Discussing the severity of the fractures to a four-month-old baby's arms was shocking. Bridget went on to explain that it had been a week before his mother took him to hospital, and that she denied any knowledge of how the injuries had occurred. There was an '*on-going investigation*' while Mohammed stayed with her. This created an atmosphere of suspicion, accusation and blame, whether verbalised or not. The matter was not resolved by the time Mohammed left this placement.

Fractures, breaks and disruptions

Just as the child had physical fractures to his arms, so there were broken and fractured relationships throughout this case. The physical fractures were mirrored in the broken relationships, beginning with the removal of Mohammed from his family and continuing in the system. Mohammed's SW went off on long-term sick leave, and Bridget's original SSW went on maternity leave. This meant that there was no sense of continuity and this had serious consequences for the placement. Bridget knew nothing about Mohammed's birth, what he weighed, or what the pregnancy and birth were like. She had no picture of his life before now.

The new SSW arrived at a point when Bridget was feeling desperate and asked for respite. Bridget wanted to be seen as capable and resilient and she put pressure on herself to cope. Asking for respite was something she was ardently opposed to:

> Bridget*: and I had said I really need respite and she had said at the time, 'you can't make a habit of it'*
> Researcher*: mmmn hmmmn*
> Bridget*: and I was really upset because I've said at the time, I'd been a foster carer for two-and-a-half years and I've never asked for respite, never (...) I wouldn't be asking you if I wasn't desperate.*

Bridget was left feeling unsupported and her desperate state not picked up on, as the SSW suggested that she might '*make a habit*' of asking for respite. As Bridget reflected later, this may not have happened had she had an existing relationship with her SSW.

There was miscommunication between the professionals and the carer, which led to misunderstanding. Both Bridget and Fiona had been led to believe that contact was going well, there were no concerns, and Mohammed would be going home. However, at the Hearing, Fiona and Bridget were surprised when the manager of the service assessing birth parents declared that Mohammed could not go home as they did not know who had caused the injuries.

Finally, there was something 'fractured' in the way the placement ended so suddenly. This is likely to have been how Mohammed experienced the ending, coming out of the blue and unexpectedly, just as it had when he was removed from his parents' care.

Living with conflicting feelings

Early in the interview, I picked up on this theme when Bridget spoke of Mohammed's parents being under suspicion of serious abuse and neglect and then told me that she liked them and they were '*a nice couple*'. Like Fiona, she was clearly struggling to reconcile these two views and felt pulled in two directions:

> *so it's difficult – I got on – very well with mum and dad, you know, I found them a very nice couple and that makes it a little bit harder because something's happened to this child.*

The contradictory thoughts can also be seen in Bridget's struggle not to sound critical of her SSW, whom she praises highly but was clearly unhappy with. There was a simultaneous desire and reluctance to criticise her, just like the simultaneous desire and reluctance to like Mohammed's parents; thoughts and feelings pulled in two directions.

She spoke of Mohammed as a delightful, adorable and rewarding child, yet he cried and was awake half the night, leading to feelings of exhaustion, despair and hopelessness. Bridget said that she wouldn't expect a four-month old baby to sleep, but said at the same time that it was not '*normal*' for a baby not to sleep all day and only for a few hours at night.

Bridget countered feelings of doubt and uncertainty about why Mohammed was crying and not sleeping when she declared confidently and emphatically that she '*knew*' what Mohammed needed: '*I knew, I knew*'. What she '*knew*' was that if she had been able to do controlled crying then she could have got Mohammed into a routine and a regular sleep pattern. However, she gave reasons why it was impossible for her to do controlled crying – her husband got up for work very early in the morning and needed to be allowed to sleep, and Mohammed shared a room with another small child. It was not until near the end of the interview that Bridget gave an indication of a personal difficulty with leaving a baby to cry, hinting that she didn't think she would have been able to do it, perhaps a fear of being identified with the cruel, neglectful parent. This left Bridget wondering if the no-sleeping would have been resolved if she'd done controlled crying, adding to her feeling of having failed the baby because she couldn't do it.

She claimed that '*everybody wants a baby in the house*' but, after this experience, she and Craig agreed that they would not take an under-one again, thus going against her own declared view that '*everybody wants a baby in the house*'.

Emotional Impact of Looking After Child

Feelings of pride, achievement and accomplishment, which were expressed during the interview, were largely overshadowed by more difficult, painful feelings. Ultimately, feelings of hopelessness and despair, and physical and mental exhaustion, became too much.

Despair

Bridget spoke of the utter exhaustion she felt, through lack of sleep and her struggle to soothe a crying infant. Following a short period of respite, during which Bridget had a break with her family, she described herself as '*on the floor*', feeling desperate and helpless.

Bridget brought up the subject of Mohammed not sleeping while talking about not having any information about his birth weight. Mohammed was a small baby – '*wee* *tiny*' and '*tiny wee baby*' – who weighed only twelve pounds when he arrived. Bridget didn't know what his birth weight had been, but while telling me this, changed mid-sentence to the '*no sleeping thing*':

> Bridget*: but I was never told, em, what he weighed when he was born. So I'm kinda saying, well, if he was nine pounds when he was born, twelve pounds is ridiculous but if he was only four pounds when he was born* (voice rising in a question) *twelve pounds maybe em and as I say that's- that's when the- the l...lack of sleeping, the no sleeping thing started, which, a four-month old baby, there's nobody expects a four-month old baby to sleep, but when he came here em it started every hour-and-a-half, every two hours, he was awake, and he was awake for anything up to two hours, so…*
> Researcher*: right. So he would only sleep for a matter of an hour or an hour and a half?*
> Bridget*: yep, yep. During the day he would sleep for maybe an hour in total from being up from half past six in the morning til about seven o'clock at night,*
> Researcher*: right*
> Bridget*: which to me is* **not** *a normal,*

She went on to tell me that she changed his diet and that this was successful in improving his appetite – '*he was a fantastic wee eater by the time he was six months*' – but that '*the sleeping thing never corrected itself*'. Her rate of speech slowed down as she said this, indicating her disappointment.

Bridget described a state of constant vigilance when Mohammed did drop off to sleep and she herself would try to catch up on some sleep:

> *and you don't sleep then you know, I would go to bed at nine but you're, you are constantly, your ears are up like this, in case you've heard him,*

Bridget said that Christmas was '*the worst Christmas I've ever had*'; she was up half the night with Mohammed while trying to organise everything for the family Christmas.

Lack of sleep led to her having no energy and feeling that there was ‘*no point in doing it*’:

> Bridget*: just thought I don’t have the energy, and you have to have energy to be a foster carer,*
> Researcher*: mmmn hmmmn,*
> Bridget*: if you don’t there’s no point in doing it,*

A cycle of negative thoughts and feelings ensued when her own sleep pattern was so disrupted and she was unable to work out why Mohammed wasn’t sleeping. She became pessimistic and despairing: ‘*I don’t think anything would have helped*’ and even had thoughts of giving up fostering:

> Bridget*: I was kinda saying this is, I’m not enjoying this, and what I didn’t want to happen was, to put us off fostering –*
> Researcher*: mmmn hmmmn*
> Bridget*: because that’s the stage it would have got to if Mohammed had not left, I would’ve said, I can’t do this anymore,*

She added that she didn’t want to do that because ‘*fostering’s the best thing I think we’ve ever did*’.

Loss of routine

Bridget was a woman who liked to have a regular routine - ‘*the routine is a set routine from the minute they walk in the door*’. However, she found that it was impossible to have her usual routine due to the demands on her time and her own fatigue. She had to attend a Hearing every three weeks, and she also had to take Mohammed for contact with his parents three times a week. This led to her feeling out of sorts and dissatisfied, not able to enjoy the fresh air and walking she was used to having daily:

> Bridget*: But I would usually have had that baby in the pram every single day, out for a walk, and it never happened like that, it never quite happened.*
> Researcher*: because you weren’t in any kind of routine, were you?*
> Bridget*: No. There was no routine, I was too tired.*

This led to feelings of frustration and dissatisfaction, adding to the feeling of not being in control.

Prolonged Uncertainty

Mohammed was not expected to remain for long in foster care. There were Hearings every three weeks at which Mohammed was expected to return home. This led to a cycle of Bridget's hopes being raised then dashed each time she attended a Hearing:

> *Every three weeks I would have my hopes up, that he was going to, uhu, he would be going, em, I would say I can do another three weeks, I can do another three weeks, and it never happened.*

Pointlessness

Bridget spoke about the contact with birth family, to which she took Mohammed each time. She realised that she was spending a lot of time facilitating contact; in other words, promoting a relationship with parents who were under suspicion of having harmed their child, or at least of not having taken him to hospital when he was hurt. Bridget used the word '*pointless*' when talking about this experience, it was '*pointless*' for her as all she could do was hang around the shopping centre waiting until contact was over and she could take Mohammed home.

Physical abuse

Bridget gave as the reason for Mohammed being accommodated, '*unexplained injuries*'. Mohammed arriving in placement with his arm in a plaster cast set the scene, as it were, for the placement; as Bridget said, she '*felt sorry for him*'. The results of the physical assault were visible, this fact was inescapable. Mohammed had been, and may still have been, in terrible pain. Dark thoughts about what people are capable of were unavoidable.

Guilt and disappointment

Bridget described feeling '*terrible*' and '*horrible*' when having to end the placement, and feeling that she'd '*failed*' the baby, his parents, and herself:

> *I didn't want to, as I keep saying, I didn't want Mohammed to go away, I don't want any placement ever to break down. I wanted to be able say after twenty years fostering that there was not a child who ever* (takes a breath in and changes tack).

She felt guilty about letting Mohammed down – '*I just felt as if I had failed the baby*' – and also about letting his parents down:

> *And then, telling his mum and dad that* (pause) *that he was moving on I thought oh…this is…it was horrible, absolutely horrible.*

She also felt that she was causing her own children to feel disappointed and sorry – '*it's not fair, why does he have to go?*' The feelings of guilt were combined with feelings of anger at the lack of support and how things might have been different had regular respite been put in place.

She described Mohammed as '*the most beautiful baby I've ever seen*' and later as '*a picture baby*'. The physical attractiveness of the baby seems to make it all the more difficult that the placement did not work out. However, there is something about '*a picture baby*' which is not quite real, indicating, perhaps, a lack of connection with a real baby, or a distancing process in order to make the breakdown and her guilt more bearable.

4.3.3 Process of the interview

Bridget was a bright, animated woman, lively, interested and eager to talk. She spoke quickly, often not waiting for me to complete a question before beginning to answer. At the time, it felt straightforward and I didn't have to go through my interview systematically because Bridget had usually answered the questions in the course of her account.

Her feelings about the placement emerged in the content of her account, but also at times in her use of emphatic speech, or her speech slowing down. Despite her liveliness and enthusiasm, when analysing the data it was clear that the emotional experience of the placement had had a significant impact on Bridget and her state of mind. The combination of lack of knowledge about the child, feeling unsupported and misunderstood by her SSW, led to her feeling very much lost and having to cope alone.

4.3.4 SSW Interview

Brenda was a social worker with 25 years' experience. She seemed reluctant to do the interview, despite having agreed and signed the consent form, and told me before the interview started that she probably wouldn't be able to tell me much as she took on the case when her colleague went on maternity leave. She was assigned to the case one month after Mohammed was placed with Bridget and Craig.

She admitted that her knowledge of the case was '*limited*'; she had no memory or knowledge of the circumstances under which Mohammed had arrived. At the time, I remember feeling angry on Bridget's behalf that Brenda appeared not to have taken the time to furnish herself with information which was important to the placement, nor had she attended any Hearings, although Bridget had attended these on a regular basis.

She thought she had not met Mohammed, that he had not been there when she went to visit. Brenda said she had no ideas as to why Mohamed was crying and not sleeping.

The interview was punctuated with awkward silences due to Brenda not knowing and being unable to answer my questions:

> Researcher*: can you remember, at the time, what advice you offered Bridget?*

> Brenda: *eh* (7 seconds silence) *not off the top of my head, I can't really, em, I mean it was quite short-lived my involvement, em, October, November, December, I think he went on respite again around that time, eh, I can't really.*

Apart from being unable to recall what advice she gave Bridget, if any, there was a discrepancy in her account of whether or not respite had been provided. She said here that there was respite in December, but Bridget recalled that this period of respite, which had been pre-arranged, was forgotten about and did not go ahead.

Brenda said that her task was difficult due to not knowing the child and not having a relationship with Bridget or knowing her circumstances. However, she didn't think she could have done anything differently, saying '*but I think the problem was, eh, insurmountable*' and that their new relationship made no difference to the final result of the placement breaking down.

When I said we had reached the end of the interview Brenda visibly relaxed. Her conversation began to flow more naturally and I realised that she must have been anxious. It was only now that she hinted at a busy schedule, or an unmanageable workload: '*I mean, you've got a hundred other things going on at the same time*'.

My countertransference experience of frustration and disappointment at Brenda's lack of knowledge of the case gave me first-hand experience of how misunderstood and unsupported Bridget had felt at the time. It provided a good example of how factors within the wider system interfered directly with the placement i.e. the fact that Brenda had to take on extra work when her colleague went on maternity leave, that her first contact with Bridget involved a request for respite, and how little space she had to carry yet another story in her head.

4.3.5 Support

- During the placement, the carers' SSW went on maternity leave and a new worker was assigned to them. This had a significant impact on their experience of feeling supported and understood as the relationship began when the placement was already under stress. Bridget's own view was that asking for support indicated a kind of failure.

- Fiona had three changes of manager in a short space of time. She admitted that she tended to rely more on peers but that often there wasn't time for this and '*you just need to get on with it*'.
- Brenda felt unsupported with a heavy workload.

4.3.6 Reflections

This case stood out as being unlike the other five cases. Mohammed was the only child with no history of social work involvement and the only child from a minority ethnic family. This was also a case where contact with birth family was regular and frequent (three-times weekly). Kenrick (2010) has drawn attention to the risk of discontinuity of care where there is intensive contact with birth parents, with frequent separations and reunions for the child, and disruptions to routine having a potentially detrimental impact on the placement.

The issue of the child not being able to sleep, and therefore the carer not being able to sleep, appeared as the main concern of the placement and was cited as the reason for the breakdown. Despite this 'single issue', there was an outpouring of feelings relating to the emotional impact on the carer of trying to provide care for the child. Bridget experienced feelings of desperation, anger, frustration, helplessness, disappointment, sadness, and found herself in a state of constant vigilance, feelings which we could imagine were projected into her by the child, but which she had no way of thinking about or processing.

This case is characterised by what I see as an absence of any containing process for the carer, the child, and the system around them; a failure to think on an emotional level about the child's disturbance; and an unconscious reluctance to become emotionally involved.

Bion (1962:95) writes of failures in the process of 'container-contained', of thinking and not thinking, knowing and not knowing. In this case, the 'K-link' had become ‘minus K’, with a turning away from knowing truth and reality. A state of ‘minus K’ generates an allegiance to anti-development rather than to growth and development.

Uncertainty and indecision permeated the system. This appeared at many levels, including Bridget’s uncertainty about Mohammed’s early life, and the lack of decision-making regarding Mohammed’s long-term care, due in part to the absence of any person taking responsibility for the injuries. Bridget believed that Mohammed would not be staying for long and was reminded of this possibility every three weeks at Hearings. She was, therefore, living with an anticipated loss. This uncertainty and anticipated loss is contradictory to the forming of a relationship – why would a carer invest emotionally in a relationship which is going to be short-lived? (see Goldstein, Freud and Solnit, 1973).

There was a reluctance to think too deeply about a case where there were ‘*unexplained injuries*’ and all that goes with that, including the mystery surrounding the cause of the injuries and what one imagines to have happened. The idea of fractures and breaks – physically on the child, but also symbolically in the relationships around the child – was an important theme in this case; however, it was not thought about in a way which might bring understanding to the child’s distress.

There was a failure to think on an emotional level about the no-sleeping and what it might mean. There was a focus on possible physical causes rather than imagining what the child’s emotional state might be. Sleep problems can be ‘among the most undermining troubles a parent has to deal with’ (Daws, 1989:1) producing doubts in parents about their parenting abilities. Daws noted the need to pay attention to parental or carer experiences of separation and loss. In this case, however, these experiences were not thought about.

The idea of holding opposing and contradictory views, and living with conflicting feelings was another important theme. Bridget’s thoughts swung from one extreme to another: are these good parents or have they hurt and abused their child? Am I a good carer or is it something about me which is stopping this child from sleeping? Do I know what I'm doing or have I lost all my parenting skills? (Identification with inadequate or maltreating parent).

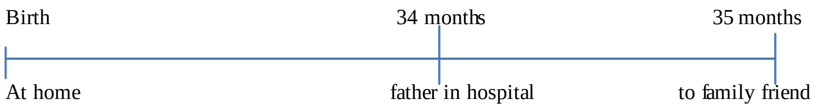
Finally, there was an issue which I felt was pertinent to this case, but which was not brought up by either Bridget or Brenda. This was Mohammed's colour and culture, which were different than Bridget's, Brenda's and Fiona's. As an outside observer, also of the prevailing White culture, I thought that this would be something which would have been considered as having a bearing on how comfortable and settled Mohammed felt. The issue was discussed only briefly in Fiona's interview, when I asked about it directly. It seemed that no-one had asked about Mohammed's previous sleeping arrangements, and family or cultural issues. Was there a reluctance to raise ethnic difference as a possible factor in the breakdown for fear of becoming entangled in the potentially controversial subject of race and ethnicity?

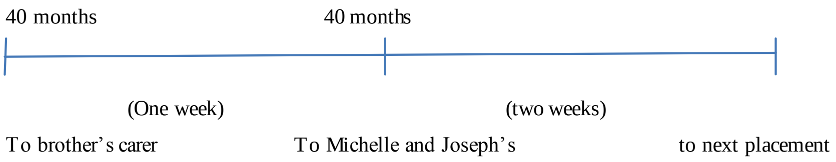
4.4 CASE THREE: GEMMA

Carers: **Michelle and Joseph**
Child: **Gemma**
Age at time of placement: **40 months**
Length of placement: **2 weeks**
Who interviewed: Michelle
Where interviewed: Researcher's office
Time lapse between end
of placement and interview: 8 months
SW: **Anita**
SSW: **Donna**
Reason for breakdown: child didn't 'fit'; wrong time

Box 3

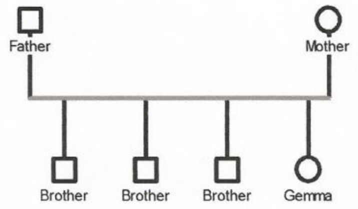
Timeline



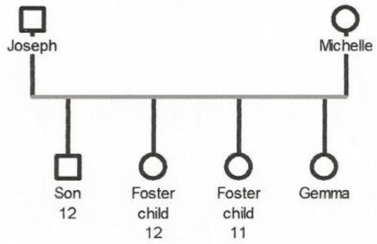


Genograms

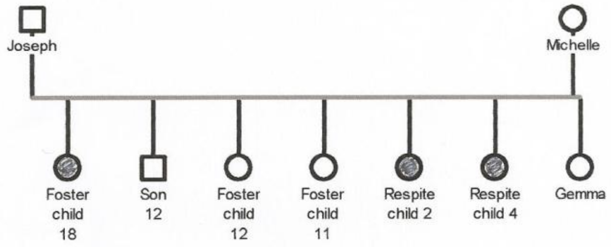
Genogram 1: Gemma's family of origin



Genogram 2: In carers' house at time of Gemma's placement



Genogram 3: In the mind of carers



4.4.1 Social Worker Interview

Background

Gemma was the youngest of four children. There had been intermittent social work involvement at the birth of each child. Both parents had addiction issues and her father, who had been the main carer, became ill and was hospitalised. It was thought that he may not survive. Mum was found heavily under the influence and all the children were accommodated. Mum agreed for Gemma, age 35 months, to stay with a family friend. Five months later, mum withdrew her consent to this arrangement. Anita obtained a Child Protection Order and Gemma was moved on an emergency basis to a placement outwith the city, beside her brother. After Gemma was accommodated, contact arrangements were put in place, but mum's attendance at these was erratic, giving Gemma the worrying experience of being left yet again by mum.

Placements

The move outwith the city was one of the events which aroused Anita's anger, as, when she arrived with Gemma at the placement, the carer said to her, '*I've agreed to take her but I don't know that I'll be able to keep her*'. Anita was furious about this and felt she had been misled by placement services. She said that had it not been late at night and far from her base, she would not have left Gemma there. Within days, this carer was asking for Gemma to be moved. Gemma moved from this placement after one week. Anita felt she was '*in a Catch 22 situation*' because there was pressure to get Gemma out of the placement. She described the carer as saying, '*you get her out of here now*'. This illustrates the pressure social workers are placed under and how they often do not have time to match children to carers.

Anita felt she had enough information about Gemma and her needs but described these only in very general terms, for example:

> *she's got behavioural problems because she's lacked parental boundaries and em...parental guidance, parental care*

She noted that her speech was poor and had organised speech therapy for her. She described Gemma as '*bright, very hyper, eh sociable wee girl*'.

With Anita, I remember feeling that there was a conflict of researcher/interviewee agendas, in that I didn't get to hear about the relationship between Gemma and her carers as Anita was so caught up in her anger towards the system and how it had, in her opinion, caused harm to Gemma. When I tried to focus on the placement with Michelle and Joseph, Anita quickly strayed from it, back to the previous placement. When I asked what behaviour was troubling the carers, she answered vaguely:

> *em...just lack of self-awareness, temper tantrums, angry, em, lack of danger, lack of boundaries.*

Anita was unhappy with the placement when she visited, commenting that there was wood everywhere (outside) which she saw as slippery and dangerous. She did not have a good feeling about the placement but struggled to express this, '*em, I don't know, I didn't- eh, I wasn't sure if they were- I don't know*'. She felt that Michelle and Joseph were '*very negative*', '*all about Gemma's behaviours*' and thought this followed from the previous carer who had spoken negatively about Gemma. Later, she told me that she didn't think the family particularly welcomed Gemma, which is in direct contrast to what Michelle and Donna told me. She reflected that '*perhaps they weren't committed to a child that age*' and then, more definitely, '*they didn't want a child that age*'.

When I asked what her main concerns about Gemma were, she answered that her concerns were about '*the assessment by placements*' (i.e. the fostering agency). She expressed no concerns specifically about Gemma but complained bitterly about the limited information she received about the carers, bringing in her experience of this in other cases. Anita was angry and unhappy that she had to accept Donna's word that these carers would be suitable for Gemma. With much surprise, she told me, '*what normally we get is just a name and address*'. She now refuses to accept this and insists on receiving a full report on the carers: '*I want the full thing, the **full** foster carers' assessment*'. This follows her experience with Gemma and one of her siblings, as well as another group of siblings she had been involved in moving several times. She said, '*basically I've had enough now*' and '*I don't take it*'. She added, '*I don't trust your placements anymore*'.

Anita received an email from the SSW, outlining the difficulties in the placement and stating Michelle and Joseph's request to have her moved. The SSW wrote that: '*she's an extremely demanding child that needs to be continually occupied'* and '*major temper tantrums, throwing herself on the floor and screaming and shouting'*. Anita read this from the file. She defended Gemma, telling me, '*she's very insecure, she'd just been moved three times*' and '*she was just a wee girl*'.

Anita described to me, almost in passing amidst the complaints against placement services, a very moving scene when she was moving Gemma from this placement to the next one:

> *she was very distressed when she went, she was clinging onto me...you know the system's damaging a wee girl, I can see it in front of my eyes, just clinging on and clinging on and, she's saying 'nita, nita'.*

This scene captures the full emotional impact of Anita's task and how disagreeable it was to her.

4.4.2 Carer Interview

Introduction

An initial re-reading of this interview, and thinking about it afterwards, left me feeling that I didn't have a clear picture of the child. For some reason, it was difficult to get a real sense of who she was, although there are clear descriptions, not only of her screaming and making constant demands for Michelle's presence and attention, but also of happier moments of constructive play together and humorous comments made by Gemma.

Fate

Michelle’s life-view was apparent throughout the interview in her way of explaining life events. I think of her as a ‘fatalist’, someone who believes that certain things are ‘*meant to be*’ and that there is a higher power controlling events. This was conveyed in phrases she used, such as ‘*who knows what’s in the future*’. It is a philosophy which permeated the interview and has significance for Michelle’s decision to end the placement, something she continued to question herself about, eight months after the event.

The idea was introduced early in the interview, when talking about why Michelle became a foster carer. Michelle and Frank wanted to have lots of children but, having had one child, Michelle did not become pregnant again – ‘*it wasn’t to be*’, said Michelle. This led to their decision to foster. She and her husband had fostered many children, for fifteen years. As it turned out, Michelle did have another child, some years after the decision to foster.

Michelle was troubled – perhaps tortured would be more accurate – by her decision to end the placement with Gemma and continued to question if it had been the right decision. She told me a story of a chance meeting with Gemma and her new carers, on the same day that she left the placement. Michelle said:

> *that was God telling me I should have kept that wee girl, that was me getting punished for that, I should’ve kept her.*

Later on, she returned to the story and said:

> *oh my goodness, this is – it should’ve been, it should’ve been that I was the one.*

These words, and her way of thinking about the event, capture how tortured she was, and is, by her decision to let Gemma go. Michelle felt so guilty about it that she spoke of '*punishment*' from God, and the idea that she was '*the one'*.

Violent Mum

When I asked if Michelle knew why Gemma was accommodated she replied vaguely:

> *I think it was neglect, with mum, I think, I'm not sure, you can maybe check that, right, but I'm sure it was something to do with mum, I think mum was a bit violent towards dad.*

She then went on to say something about Gemma's siblings and the fact that Gemma broke out in chicken pox two days after she arrived in placement, but returned to birth mum and said, '*mum was very violent, I think'.* Michelle was aware that mum lived in the same area as her and wondered if she went to the same shopping areas. Despite the fact that she had never met Gemma's mum, she loomed large in her mind. The idea of a violent mum took hold in Michelle's mind and she confessed that she was frightened that she would bump into her, and even be '*violently attacked'* by her, having heard that mum often '*violently attacked'* Gemma's father. Michelle confessed that this:

> *might have a wee bit to do with something with the placement breaking down as well*

admitting just how strong her fear was.

In fact, the fear got into Michelle so concretely that she found herself behaving like a hyper-vigilant child:

> *I felt as if, you know, when- when I was with Gemma, beautiful wee girl, absolutely gorgeous wee girl, and when I was with her I kept sort of, you know, checking and looking round about me, even though I didn't know what I was looking for cos I'd never met the mum, but I always felt as if I was always, oh my goodness,*

Michelle's thoughts ran wild, much in the way of a terrified child. She says:

> *I think her mum would've just went for any of us, even put my windows in or something like that, you know, she seemed the type that would do that*

These comments about mum came in the first few minutes of the interview and, thereafter, few further references were made to mum. However, it remained close to the front of Michelle's mind and, when I asked what she thought about Gemma screaming and hitting out at other children, she said, '*I think she was copying mum'.*

Fit and difference

In this more than in any of the other cases, the child just did not seem to fit with the family, a comment which appeared several times throughout the interview: *Cos she just would- didn't seem to fit into our lifestyle.* 'S*he's not for us*' and '*this isn't the right wee girl for us*' were phrases which appeared throughout. This family had a system, as all families do, which Gemma did not fit into, or which was too disrupted and unsettled by her presence.

Michelle told me how Gemma liked to run around naked:

> *I mean when it was bedtime she was quite willing to fling her clothes off and get absolutely naked and I would say to her, you know, I mean, you need to get your clothes on, you know what I mean, take off your top first and then put your top on, and then, take your bottom off and then put your bottom on, you know, and not be completely naked,*

She doesn't believe in children running around naked; as she says moments later, '*no, no, no, that's not how it works*'. This does not fit with the mores of Michelle's family and her modesty is challenged by this. Gemma used to wake up early in the morning, often at five am. This family was not used to such early waking. *'That was probably my breaking point as well'* said Michelle. Gemma '*didn't seem to fit into our lifestyle...cos* *we don't wake up at six o' clock in the morning*'. She later said that it was the '*early morning thing*' as well as the screaming, which she found most challenging.

Loss of sense of self

There are several ways in which Michelle's sense of confidence and security in herself was undermined or shaken by the experience of looking after Gemma. I have already described how Michelle became hyper-vigilant when looking over her shoulder for Gemma's mum. She also found herself giving in to Gemma in ways she usually would not, in her desperation to placate her.

Michelle described Gemma in the midst of a screaming episode, not responding to her attempts to calm her down. She noted that she did quieten when she was with her:

> *but as soon as I went out the door, the screaming was back again and I thought this is- I ended up giving in to her, and bringing her down to the living room*

This acknowledgement of '*giving in to her*' indicates a feeling of defeat, of having to alter one's usual ways of doing things.

As well as feeling at a complete loss as to how to quieten Gemma's screaming, she found that all her time was taken up with Gemma who didn't leave her side for a moment. Michelle described how her sense of personal space was lost by Gemma's need to be with her at all times. She spoke of Gemma being '*glued*' to her, '*completely glued to my feet*'. She described a loss of '*freedom*' and '*I need my space back*'; '*I can't breathe'* she said, '*can't go for a pee'*. These words strongly convey how trapped she felt, as though her entire life had been taken over by this child.

She reached a point where she questioned her own way of doing things, blaming herself, wondering if she spoiled Gemma, when, in fact, she performed an instinctively caring and sensitive act:

> *Even in her bed, I don't know if she was just told to go to bed when she was with her mum and she just went down and went to sleep, but maybe that's my fault, maybe I spoiled her a wee bit and went into bed with her for a wee while and lay with her until she went to sleep and read her a wee book and then she went to sleep and then I came out and she was fine,*

She began to doubt what she knew, to doubt her instincts.

The screaming came through as a constant feature of the placement as it was described frequently throughout the interview. Michelle said it was the thing which was most distressing to her: '*I didn't really know how to deal with it myself*' and '*I probably ended up giving in to her*'. In this description of the screaming, we see how Michelle was pushed into a similar state of mind as Gemma:

> *I couldn't deal with it, you know? I didn't know how to deal with it…this wee girl is so upset…and I would think, why is that? …and I had sometimes felt as if I wanted to scream with her,*

Later, when describing bath time to me, Michelle told me that she did end up screaming with Gemma:

> *I remember another nightmare as well – when I was doing her hair…and that was an absolute screaming match as well, trying to give her a shower…she was* ***absolutely*** *screaming the place down…every single time, mmmn hmmmn, screaming the place down when it was a shower and, I remember one time it was that bad, and she was really, really screaming, so when I took her into the bathroom I was screaming as well, I was screaming at her, but I realised after it, that that wasn't the thing to do, you know, I thought to myself, that's not good, that's not how to deal with this.*

This is a description of a desperate scene, where Michelle was really pushed to the edge, feeling frantic herself and not knowing what to do. Michelle told me that, when it was all over, '*I would just go back to my husband and cry'*.

It reached the stage where Michelle realised that it was affecting her relationships with everyone and noted that her husband commented on how changed she was:

> *And I think it was probably draining me, so then I probably wasn't being good to everybody, my poor husband probably had to think, oh my goodness, this isn't- I mean you're not the person that you used to be.*

Timing

Five times during the interview Michelle referred to this placement occurring at the wrong time. There were a number of events which contributed to this feeling: the family had just had two under-fives on respite; they had had no summer break; Gemma came out in chicken pox, two days after she arrived; and two older children in the house were starting High School.

Michelle explained that they had had two children on respite, each for a period of two weeks, directly before Gemma's arrival. She described these two children as very needy, describing one of them as '*very, very badly damaged*', and said they had '*run us ragged*'. They had had no summer break, just one child after another, each of them children who made great demands on her time. When I asked how they felt about a child coming to stay with them at that point, Michelle answered that they were exhausted because of the two children they'd had on respite:

> *And then Gemma came along. Now, everybody in my house loved Gemma and we all loved her to bits, she was a fantastic wee girl, and I think, I think it was us, that was the problem, not Gemma, because we were, we had – it was our summer holiday, we had taken on the wee ones and they had run us right into the ground,*

Michelle used this phrase when talking about Gemma too, *'run us right into the ground'* bringing to mind a steamroller or a freight train, leaving them all feeling flattened and totally exhausted.

Michelle suggested on two separate occasions that had Gemma come at a different time then it might have worked:

> *If it had of been* **not** *at when it was, if it was later…then I think it would've worked with Gemma, I think it would've been fine with her*

However, this is also wishful thinking, and denial of the level of need in the child.

Idealism

Idealism, or wishful thinking, is closely tied in with feelings of guilt. Throughout the interview, Michelle seemed to be saying, 'If only…' …we had been different…Gemma had been different…the time had been different…she had been able to accept comfort and stop screaming.

The feelings of guilt were such that Michelle was desperate not to 'blame' Gemma for the ending of the placement, but rather to take the blame herself: *'it was probably our fault at the end of the day'*, and again, later in the interview, *'us ourselves'* and:

> *it's just because of us, you know, I think we were the problem not really Gemma, I think it was us because we'd had the two before, em, and I think that because it was also the school holidays, it was just all at the wrong time.*

Michelle tried to take any blame away from Gemma, but, in doing so, minimised the difficulties in broad statements; however, these emerged throughout the natural course of the interview, and the descriptions spoke clearly of just how difficult it was. She said, '*I don't think there was really any problems with her*' and '*she was a wee bit screamy*'. This was a serious under-estimation of the problem, as is clear from descriptions of Gemma's frequent and prolonged spells of screaming. In fact, there was a list of 'problems' which I heard about throughout the interview, including Gemma being '*screamy*' '*violent*' and '*angry*'; she had poor speech and didn't know how to play; she didn't like the bath or shower, or having her hair done; she couldn't bear to be alone for a second and was '*glued*' to Michelle; she needed Michelle with her to fall asleep; she woke up screaming at five am; and she rejected the friendly advances of the other children. In fact, when I asked what Michelle's first impressions of her were, she answered clearly with '*lovely child*' closely followed by '*screamy*' and '*violent*' child:

> *Lovely, beautiful wee girl, lovely long hair, em, och just lovely, lovely wee lassie, em, I say a wee bit screamy ...and a wee bit violent as well.*

When talking about a time when she was successful in calming Gemma down, following an episode of screaming, Michelle said, '*lacking a bit of love, I think that was all she really needed*', as though love will cure all. Again later, '*needing love, loads of love, needing loads and loads of love*'.

Michelle wished that she could simply cuddle Gemma and keep her for ever, for Gemma to accept her comfort and her love, and to stop screaming:

> *She's such a lovely wee girl and you just want to pick her up and cuddle her and say to her right, you're going to be here for ever and this is you kept here and never move on again, you know what I mean, she's so lovely*

She just wished that Gemma could accept her comfort.

> *I mean I loved her to bits – still do. You know I still think, maybe that wasn't the right decision, you know, maybe we should just have kept her, maybe it would've worked out, you know what I mean,*

Michelle wished it could have worked out, but this is to deny or ignore or minimise the very real problems with which they were faced as a family, and how much having Gemma affected their daily lives.

Michelle continued to be racked with guilt about the decision and whether it was the right one or not. When I asked her what were her main concerns about Gemma at the time, Michelle did not answer with concerns about her behaviour but whether or not she was doing the right thing in ending the placement:

> *Main concerns somewhere good to stay, somewhere nice to look after her, somebody that she would really love her and give her lots of love…and I hope she had a good life.*

4.4.3 Process of the interview

This was the longest interview of all with the greatest word count, a reflection of the nature of the experience and Michelle's need to pour it out to me.

In my notes, which I made after the interview, I wrote that,

> *I felt this was an emotional interview which felt difficult to bring to a close. I felt slightly anxious about her going off on her own, as though something hadn't been properly finished.*

I wondered at the time if this was a reflection on how Michelle felt about ending the placement and that there were still many feelings left over.

4.4.4 SSW Interview

Donna had worked with Michelle and Joseph for four years before Gemma's arrival and felt she had a good working relationship with them and knew them well. She described them as '*very nurturing carers*' who have *'the whole child at the centre*'. She said that, despite this, they lacked confidence in their own abilities, that they sometimes tended to panic but she felt they were capable. However, she acknowledged that they did not know what to do about Gemma's screaming, '*they can't make it stop*' and '*they just don't know how to manage it*'.

It was a '*long time*' before they got any background information on Gemma. She noted the importance of having background information, and how carers could react in a way which isn't helpful to a child if they know little about her: '*they could either escalate or de-escalate a situation in a minute*'.

She believed that background information is '*vital*', adding that one of her biggest challenges is trying to get carers to understand the detrimental effect the birth family can have, even on very young children. Speaking of carers in general, she said:

> *I think they've kinda got this wee illusion of poor little orphan children.*

She commented that the children they accommodate now are '*more damaged*', noting the effects of parental addiction and the influence of pre-natal exposure to drugs and alcohol.

Donna recalled being under pressure to find a placement for Gemma, late on a Friday afternoon, when the carer outside Glasgow was calling for her to be moved right away. She thought now that the placement with Michelle and Joseph wasn't '*an appropriate placement*' and blamed herself for this, despite the pressure on her to find somewhere. She noted that the carers probably felt '*left*' and '*unsupported*', on their own with Gemma over the first weekend, with little or no information. Despite the pressure on her to find somewhere urgently for Gemma, she blamed herself for not having information: '*I should've known more about this wee girl before placing her*'.

Donna felt that the house was a '*happy settled place*' at the time of Gemma's arrival, and that the carers were '*ready for a challenge*'. However, this sense of being settled was quickly unbalanced as she noted how disruptive Gemma's arrival was for the family: '*they felt that Gemma come in and it was like mass chaos*' and that she had '*different routines completely*'.

4.4.5 Support

- Carer well supported by her SSW. Apparently little support from her husband, who felt absent until the end of the interview.

- SW felt unsupported, particularly in the emotionally demanding task of moving the child: '*any support would be good*'.
- Although SSW felt she had supported the carers during the placement, and reflected that the experience led to increased trust in their relationship, she felt guilty and blamed herself for, as she saw it, mis-placing the child with them.

4.4.6 Reflections

In both Michelle's and Anita's interview, I was left feeling I did not gain a clear picture of the child. I have three ideas to explain this: one is a reluctance to see Gemma as a 'disturbed child', a defence against acknowledging the harmful effects of her early experiences. The second idea is that Michelle was engulfed by Gemma's screaming and unable to see through it to the needy child, the effects of a powerful projection. The third idea concerns guilt, which emerged as a theme in the data analysis. The powerful feelings of guilt experienced by both Michelle and Anita at times got in the way of acknowledging the level of distress and disturbance Gemma displayed.

While the idea of the 'disturbed child' was kept out, the idea of the 'violent mum' got right inside Michelle's mind and assumed a powerful place there, casting a frightening cloud over everything. Michelle became hyper-vigilant, with a loss of a feeling of safety in her own neighbourhood. This gives us an insight into what it must have been like for Gemma with a terrifying object in the background (if not foreground) with the potential for violence. I wonder too, if Michelle had an unconscious fear of being identified with the 'violent mum', and harboured an anxiety about perpetuating damage to the child?

Michelle experienced an erosion of her confidence in her parenting skills, doubting herself, her knowledge, and her instincts and judgement. With Gemma's constant demands for proximity, Michelle felt trapped, with a loss of freedom, loss of sense of space, all semblance of 'life as usual' gone. If we think in terms of attachment behaviour, Gemma was seeking safety and protection and displaying her need to find a primary attachment figure. The contradictory messages given out by Gemma, of needing Michelle to be close to her at all times, yet screaming and rejecting Michelle's offers of comfort and care, are typical of a child with a pattern of disorganised attachment. Michelle's attachment relationships were also affected. With Gemma's main focus on Michelle, Joseph quickly became sidelined or pushed out, leading to a less supportive or collaborative relationship between them.

The idea of the placement being at the wrong time seems a credible reason for why things didn't work out. This meant that Michelle could blame circumstances for the breakdown, rather than placing any blame on the child. However, these are 'practical' rather than 'emotional' reasons, less painful and anxiety provoking to think about. In the interview, the dialogue moved between Michelle denying that Gemma was a problem, and placing all the blame on herself, to providing detailed accounts of how stressful and exhausting it was to look after her. What Michelle spoke about most passionately was the experience of Gemma screaming and needing to be with her all the time; but the way in which she explained the breakdown was in relation to bad timing and not fitting into the family.

In Anita's interview, I was left with a strong sense of her anger at the way the system not only lets children down but potentially causes them further harm. Her anger was connected with the guilt she was carrying about the failures of the system to provide a stable placement for Gemma. All the anger and rage at the misfortunes which befell the child were experienced and expressed by her, leaving her feeling like the cruel person who is responsible for moving a child around. Again, the carer or worker is left to carry the negative aspects of the experience by being led to feel like the neglecting and maltreating parent. Anita received insufficient support for such an emotionally demanding task, her thoughts becoming so consumed by anger that the experience of the child was inadvertently obscured. Woodhouse and Pengelly (1991: 177) have written of how SWs are often the first to blame themselves, and carry 'an anxiety that they might be perpetrating the very failures of parenting which they were committed to making good'.

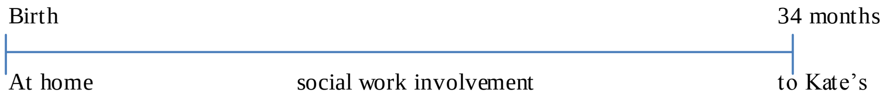
The experience of loss was important in this case, too. Michelle had recently ‘lost’ a child who had been living with her for many years, when she moved on to independent living. She had also just lost the two children who had been on respite with her. Gemma had moved placement three times in the previous six months. Again, these losses were not considered or reflected upon as having a significant bearing on both the carer’s and the child’s state of mind.

4.5 CASE FOUR: JESS

Carer: **Kate**
Child: **Jess**
Age at time of placement: **34 months**
Length of placement: **8 weeks**
Who interviewed: Kate
Where interviewed: Researcher's office
Time lapse between end
of placement and interview: 11 months
SW: **Martin**
SSW: **Amina**
Reason for breakdown: masturbation/risk to other children

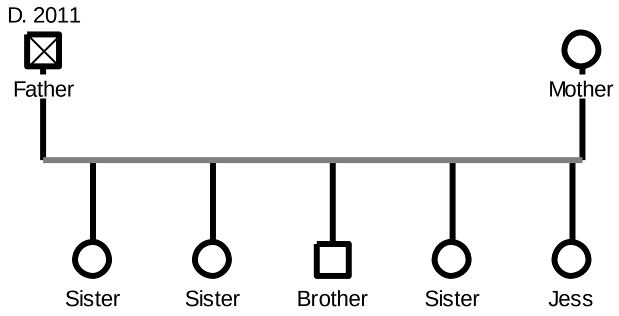
BOX 4.1

Timeline

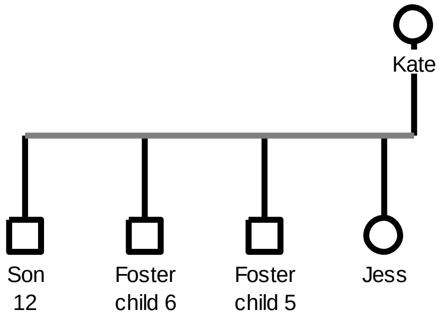


Genograms

Genogram 1: Jess's family of origin



Genogram 2: In carer's house at time of Jess's placement



4.5.1 Social Worker Interview

Background

Jess was accommodated separately from her four siblings, who went to different placements. Her social worker, Martin, had been working with the family for eight months prior to accommodation, but Jess's mum and older siblings had been known to social services for much longer. There had been many moves of house in and around Glasgow and the family were known to several social work departments. Medical appointments were missed, school and nursery attendance was erratic, and Martin said there were more than the ordinary number of falls and tumbles, suggesting a lack of supervision. The home and the children were in '*appalling physical condition*'. Martin said he had lost count of the number of times the children had head lice. He admitted to being '*horrified*' that they weren't already accommodated. Despite support being provided to mum three times per day there were no improvements.

Mum's relationships were characterised by domestic violence and there was conflict with neighbours. There was no mention of Jess's father, with whom she had no contact, until quite late in the interview, when Martin revealed that he had been found dead in the river, not long before.

Martin did not expect Jess or her siblings to be returned to mum's care and as the children settled into their placements, more information emerged about the neglect they had experienced.

Martin noted that Jess did not seem upset at being separated from her mum and she settled easily with Kate. He described her as a '*friendly*' girl, '*always glad to see you*'. However, he then used the adjectives '*adventurous*', '*reckless*' and '*brave*' to describe her, words which would suggest insecure attachment status.

Placement

Jess came straight from home to Kate's house on an emergency basis; Martin said that the move had been '*hastily arranged'*. Kate already had two foster children in placement, the number she was registered to take, therefore by taking Jess she was going one over numbers. She also had a birth child, age twelve.

The main issue within the placement was that Jess was masturbating. Martin was reluctant to accept and label it as '*sexualised behaviour*' although he recognised and understood why people '*panic*' when such behaviour is displayed. He thought that Kate was '*shocked*' by the behaviour, but he didn't think it was helpful, '*everybody jumping to conclusions'*. Martin admitted that he had little experience or training in this area but thought that there were other reasons why she could be doing this, not necessarily that she had been sexually abused.

Martin saw the behaviour more as a self-soothing or comforting activity, as a result of the lack of emotional contact with mum. However, later in the interview, he used the phrase '*problematic sexualised behaviours*', as though admitting the possibility that this is what it might be, while preferring to think about Jess's behaviour as having a meaning other than sexual. Martin found it puzzling and inexplicable that this touching was not reported in either of Jess's next placements. As he wondered about this, and said, '*maybe there isn't an explanation*', he recalled that a colleague saw Jess do this a couple of days before being accommodated.

Martin became aware that there were problems within the placement after Kate returned from holiday, around three-to-four weeks after being placed. Although Kate had been concerned before going on holiday, Martin had not known about this. The difficulty was reported to him as Jess '*touching herself inappropriately on her genitals*'. Martin felt that, by the time he heard about it, Kate had already made up her mind that the placement should end. Like Kate, he used the word '*sad*' to describe how he felt about the placement breaking down.

4.5.2 Carer Interview

Incongruity/Paradox

I was struck by the way in which Kate described Jess in contradictory or conflicting ways, sometimes in one breath, using words to describe loveliness and attractiveness alongside words to describe a fierce temper and a tendency to attack herself and others. This proximity of two opposing notions brings together the two extremes with which Kate was confronted in looking after Jess; it also highlights how unnerving and disconcerting it was to be faced with a child who at one moment could be viewed as angelic and, at the next, monstrous.

This idea, of being faced with something quite incongruous within one child, became apparent as soon as Kate began to describe Jess and her arrival in her home. She gave a description of a '*lovely', 'gorgeous', 'adorable'* little girl, who, once you looked just a little closer was '*filthy*', couldn't talk or walk very well, seemed inseparable from a '*filthy*' doll, and whose hair was crawling with lice. All of this was described to me within approximately thirty seconds. It captured vividly the experience of being faced with a beautiful, angelic child, but who, in fact, had been severely neglected and was developmentally delayed. As the interview progressed, this was brought closer together until the 'incongruity/paradox' was found within one sentence: '*she was absolutely adorable, but what a temper*' and '*she would hurt herself, she could hurt somebody else, she was gorgeous'*.

Masturbation – comfort, arousal or dissociation?

Kate introduced the subject of masturbation early in the interview, as though she had to get it out in the open as soon as possible. She mispronounced the word, masturbation, each time she said it. She told me that Jess was still in nappies, although she was almost three, and that *'the hands were always down the nappy'*. Kate's reaction was to look for an explanation, perhaps she had an infection, or perhaps she was sweating, *'but no, as the days went on, she was mastrubating'* (sic).

Jess used to masturbate in the bath and when her nappy was taken off. Kate told me about the noises Jess made masturbating in her cot before going to sleep, and how uncomfortable her 12-year-old son felt: '*he would be in the next room and he would hear her in her cot*'. The difficulty of taking in this idea of a sexualised child was highlighted when Kate spoke about how Martin seemed reluctant to accept that this was masturbation, as though it was too dreadful to contemplate:

> *I don't think Martin realised. I don't think he was taking in what I was saying,*

Kate asked (rhetorically):

> *a wee thing like that – how...how does she manage to know?*

as though it was beyond comprehension that such a small child could know about sex. Kate added, '*it was horrible'*, using a word which emphasised the strength of feeling attached to it.

Kate said it was easier for her to cope with the masturbation (than it was for the other children) and that at times she could divert Jess. However, if Jess wanted to do it, Kate emphasised that you could not stop her or divert her away from it. When I asked what happened when Kate tried to talk to Jess if she was masturbating, Kate described a noise Jess made, '*uh, uh*', which I thought indicated '*keep away, don't disturb me*', and Kate agreed. It was as though she went into an unreachable, solitary, 'do not disturb' place. At times she got comfort or arousal from the doll, but at other times, she entered a state of dissociation. In the absence of a maternal figure providing for her needs, Jess had turned to excessive use of auto-erotic satisfactions.

Kate and her family found themselves feeling '*on edge*', wondering if Jess was going to start masturbating again. She described a state of watchfulness and alertness akin to hyper-vigilance.

The Doll

As soon as I began to hear descriptions of Jess and Kate's first impressions of her, I heard about Jess's doll. Kate told me that her speech was '*non-existent*' and she screamed. The only words she spoke were '*baba*' and '*mama*'. '*Baba*' was her doll, which went everywhere with her. Kate said, '*that doll was her life*', and '*I think that's how she interacted, with the doll'*, impressing upon me how Jess's way of being in the world was through the doll. Martin also spontaneously mentioned the doll, describing it in vivid but shocking terms:

> *It's a horrible, scabby wee doll, it looks like an alien, you know? But it's her favourite.*

On the first night with Kate, on going to bed, Jess settled easily, to Kate's surprise: '*she just lies and talks to her baba*'. Kate recalled that Jess played out sexual activity on her doll too:

> *she would put the doll's legs up and rub the doll and all that*

and, later:

> *she would lift the doll's legs up, rub its bottom. She would press the doll's legs up and down.*

Kate remembered that the only way you could distract her from this was to take her doll away. Jess would become upset at this. Kate said that she could not do this to her as it was tantamount to cruelty: '*to me, you're being bad to her, taking it away from her*'. Here, she called the doll Jess's '*comforter*'.

Kate recalled a day when the doll got lost and how she searched the whole house. She described the affection lavished on the doll when it was found. While recalling that it was impossible to wash the doll, Kate remembered that Jess also used to beat the doll up: '*and she beat the doll up all the time, she beat it up!*' She described her kicking it around the living room and then picking it up and comforting it. In the interview, Kate and I agreed that this was likely to be a re-enactment of what she had seen or even experienced.

Other Children

Kate had two foster children already placed with her before Jess came. Although they had been there only three or four weeks, they were firmly established in her mind and she appeared to have claimed them, referring to them as '*my*' foster children.

When I asked how the '*constant*' masturbating made her feel, Kate replied that she was '*worried*', but immediately added that she was '*more worried cos it was the boys*'. Her worry was immediately shifted onto the other children whose care and protection she was responsible for. Her responsibility and duty of care to these children outweighed any worry she might have in relation to herself, diverting her away from thinking about her own concern and what the masturbation meant to her.

Although the boys were older than Jess, Kate said, '*these wee boys are at an impressionable age*' showing her concern and worry that they would become corrupted if they saw what Jess was doing. Kate had to try to keep the children apart, either removing Jess or encouraging the boys to go up to their room and play, causing her to feel guilty about taking the boys away from what they were doing. Kate said that it got to the point where the boys wanted to get away from Jess masturbating, and that they would go outside to play, even if it was raining.

When talking about how stressful the situation was for her, she said:

> *I'll be honest, about six weeks out of the eight was* ***very very*** *stressful*

However, she did not seem to have been able to acknowledge this at the time or do anything about it, she felt she just had to get on with things, '*you've got to cos you've* *got other children to think of in the house*'. Her needs were put aside to think of the other children, a diversion from thinking about the impact on her of looking after Jess.

It was the thought of the harm or damage potentially being brought upon the other children which made it possible to finally end the placement. Kate acknowledged feeling guilty and feeling that she was letting Jess down, '*but you've got the other ones*' she said, and '*I've got to think of the boys'*, and *'the only main thing was the boys*'.

Preparation and Expectations

Kate received very little information about Jess's background and this remained the case throughout the placement. The information Kate received amounted to:

> *It just said that she came from a kinda disrupted house, that the, the mum was- couldn't cope and that.*

Kate thought that Jess wasn't used to the bath and didn't like getting her hair done, nor did she know how to feed herself, *'we had to feed her and all that'*. Kate was taken by surprise when she realised how delayed Jess was, and how much she had to do for and with her; she had not expected or been prepared for this.

There was a suggestion that the need to find a placement urgently for a child overrides the need for carers to be provided with information, planning and preparation. Kate said:

> *I think it would've been easier if you knew some of the background, if they had given you more information on her background, but I think most of the time they just want you to take somebody.*

She continued:

> *Whereas if you knew bef- if you knew exactly what you were getting, then you could think well I'm going to get something to look into- some- books or information on it.*

Towards the end of the interview, reflecting on how things might have been different, Kate said '*it would be helpful if you had more background reports*'. She added that it may not be possible to provide these when it's an emergency but then said:

> *These children were known to the social work, so they should – obviously they had background information on them.*

Emotional Impact of Looking After Child

When Kate was in the thick of it, looking after Jess twenty-four: seven, struggling with her touching herself and going into violent tantrums, she had to deal with a range of feelings which were potentially overwhelming (see Box 4.2).

These feelings represent the daily struggle of looking after Jess and give an insight into the emotional impact of looking after her. In the following section, I go into more detail about a few of these feelings.

Shocking and Disturbing

The interview contained material which was both shocking and disturbing in nature. At times, this led to an outpouring of material, but at other times it led to silences and ellipses and avoiding articulating the content (see Section 6.5.3).

Kate quickly realised that Jess had not been properly looked after, had not been washed or cared for, had poor speech, and her hair was infested with lice. It was a shocking picture of neglect which hit Kate within hours of Jess's arrival. It was so shocking that Kate didn't want to verbalise it and I had to ask her to do so:

> Kate*: they only dropped her off and then they went away. Em, just came in and told you, they like gave you whatever she had and it was, you couldn't even* (two seconds silence) *you don't even want to know the stuff she came with,*
> Researcher*: but could you just tell me?*

EMOTIONAL IMPACT

Shocking/disturbing

Hopelessness/helplessness

Embarrassment/discomfort

Impossible demands on time

Sadness

Heart-breaking

Worry

Stress

Need to get away

No relief

Vigilant/on edge

Interruption to ordinary life

Tried everything

Just too hard

Box 4.2

Kate needed permission – support even - to articulate it, because articulating it meant remembering it, describing it, and having to be aware of what Jess had been living through.

There was a general impression of being overwhelmed by a child who was either masturbating or banging her head and throwing herself about:

> *I've got a fireplace and I put cushions down cos she would just lie and batter her head off, she would run up and header the fridge, the cooker, the washing machine.*

and:

> *She just had no sense of banging. She would just throw herself down in the street and start banging her head.*

It seemed unpredictable, it could happen anytime, anywhere, without warning, as could the masturbating, and Kate felt that she could neither stop her nor soothe her. All she could do was to make her as safe as possible.

Hopelessness/Helplessness

Feelings of hopelessness and helplessness were captured in phrases like '*I tried and done everything*' and '*it was just too hard at the end*'. The advice she received from her SSW she had already tried:

> *everything that I'd already done, eh, and then it got to the point that I says I just can't keep her anymore.*

She was out of ideas, no one else had any ideas, what could she do?

Ordinary events, where one might expect to have a level of control and sense of predictability, were overtaken by powerful feelings. For example, giving Jess a bath was '*a nightmare'*, because she could not be distracted from masturbating. A day trip to a Leisure Park was unbearable because on the journey there, Jess was masturbating: '*we went to the Leisure Park and, on the bus the whole way…doing it*'. Kate does not articulate what it is she is doing, but it is clear what she means by her emphasis on the words '*doing it*'. Her exasperation and sense of helplessness were obvious.

One of the most hopeless moments came when Kate replied that she did not feel able to fulfil her role as a nurturing parent:

> *No. No. Yes and no, you didn't know how to help her, because, you don't know, you don't really know what's happened to her.*

Embarrassment

Kate told me that she had always been around children and she felt comfortable with children. However, much discomfort arose from being with Jess. The shame and embarrassment were evident in comments about Jess '*doing it anywhere*' including the swing park, and:

> *neighbours were commenting on her lying out the back and, eh, if you were in the shops, in the buggy.*

Demands on carer time

There were impossible demands made on her time; for example, having to make the house '*extra extra*' child friendly, so she couldn't hurt herself; and '*you couldn't watch her 24…'*. Even after Jess had left, Kate's thoughts continued to be occupied by her as she wondered with concern what might be happening to her now.

Sadness

Kate used the word '*sad*' nine times throughout the interview. For her, the masturbation was '*sad*' and '*heart-breaking*' and a sense of sadness permeated the interview:

> *it was heart-breaking, cos you think, oh a wee one that size, and she, such an adorable wee girl, you think, what these children – what, what are they going through?*

During a more reflective moment, after Kate had indicated just how stressful it had been looking after Jess, she slowed down and said, '*it was just, it was so sad*'. I noted that this was a very moving moment in the interview and we fell into silence together, as though the full impact of the situation had hit us.

Feelings of sadness and heartbreak were articulated as clearly as those of horror or disgust, or aversion to what Jess was doing. However, many of the feelings of horror, disturbance and disgust remained unarticulated. I turn now to the process of the interview, where this is explored in more detail.

4.5.3 Process of the interview

Pauses, silences and ellipses

Throughout the interview, the impact of something so shocking and disturbing often led to silences, ellipses and not articulating things. It was as though the feelings were beyond words and could not be articulated: '*you've got other children to think of, and you just felt…* (she trails off)'. What did Kate feel? Whatever it was, it was just too painful to name. This sense of shock leading to silence was repeated later in the interview when Kate described Jess pulling her own face and her own hair. I invited reflection on this and it led to a pause, a lengthy silence which contained the weight of realisation of just how distressing it was.

Occasionally, I was overtaken by the disturbing nature of the material and was momentarily unable to remain as the neutral or objective interviewer. For example, when Kate first mentioned that Jess took the other boy's hand to touch her with, I said, '*oh my goodness*', sharing my shock with Kate. At times, both Kate and I moved into and away from the subject matter, as though it became too unbearable to go on talking about it and we needed respite from such a disturbing subject. At times, we were moved to silence, or speechlessness.

The thought that Jess might have been sexually abused was clearly in Kate's mind. However, she had difficulty in reaching and pronouncing the words 'sexually abused'. I asked Kate where she thought this behaviour had come from:

> *I actually thought she had been* (stops) *I actually- my- I thought she had been abused.*

Both of us got into an exchange later in the interview, where we did not name sexual abuse, but each of us knew that is what we were talking about:

> Kate*: and then eventually we got the paediatrician to see her, and she examined her thoroughly, and she said that she hadn't been…*

> Researcher*: no evidence of…*
> Kate*: yes, she says, but that's not to say that…*

It was only later in the interview that I articulated the worry about sexual abuse which Kate was left with even after Jess had left.

Grammatical Distancing

Given that this was a short-term placement, Kate was perhaps protecting herself from becoming emotionally involved. This can be seen in the way that Kate often used the second person, a grammatical distancing technique:

> *she just takes to you right away, she would call you mama right away*

Later, Kate moved in and out of first and second person:

> *Oh yes, I felt- see in a way, I felt guilty. Because you think, well, I'm letting her- you're letting her down but, you've got the other ones,*

She almost claimed the feelings for herself, but changed from '*I'm*' to '*you're*' letting her down. Using the second person allowed her to create distance between herself and the experience of looking after Jess.

A Moral Language

Describing her touching herself, which she instinctively felt was masturbating, Kate said, '*what she's doing isn't right'*. The implication was that it's wrong, physically and morally wrong, and Kate was morally outraged. It was unnerving, caused discomfort and went against her moral code.

The word '*no*' appeared several times throughout the interview, calmly, quietly, but firmly, '*no*'. It was like a door closing, or Kate's mind closing to thinking about things or letting them in for consideration: '*she would take one of their hands (*the boys*) and* *you're like, no.*' This word, 'no', captures the idea of an authoritarian and unthinking superego. It was like a blocking of thinking.

This links with protection of the other children, who '*shouldn't*' have to see this or be exposed to it. Several times, Kate used the words '*should*' and '*shouldn't*'. In her mind, in her world, certain things should and should not be allowed to happen. Giving information should happen, the sexual corruption of children should not happen:

> *She was grabbing the wee boys' hands and I thought, no, they, they shouldn't have to deal with something like this.*

Later, when we spoke about the final decision to end the placement, she said again:

> *wee boys at that age* ***shouldn't*** *have to be put in…* (trails off).

4.5.4 SSW Interview

Amina, who job-shared and worked only two-and-a-half days per week, had worked with Kate for two years before Jess's arrival. She felt they had a good relationship, although it hadn't been easy as Kate had been '*sensitive to…sharing of information*' and '*I didn't think that she found it easy to, to kind of tell you stuff*'. This was something they had worked on, however, and Amina felt that it had improved.

Amina returned to work on a Monday to find that Jess had been placed with Kate. Amina knew that Jess had been placed in an emergency with little background information provided, and that it took Kate '*over numbers*'. This suggests a desperation in the system to accommodate Jess urgently.

When I asked what Amina remembered of what Kate told her about Jess at the time, she answered vaguely:

> *I think, basically, she was saying that, em, I think the biggest issue was, you know, that she wanted to be in the*

> *pram, that she was eh very unsettled, she couldn't seem to console her, that was my sense of it now.*

She avoided naming the issue which was troubling Kate, i.e. masturbation, reaching this, tentatively, a little later:

> *She either wanted to be in her buggy or in the, the, wherever she lay, that she got into the buggy and then she would start-start to touch her bottom.*

I clarified that by '*bottom*' she meant *'vagina'*, to which she replied, *'yes, yes, yes'*. Amina thought that Kate found this touching *'really uncomfortable'*, particularly because of *'the other children'*. Amina also remembered Jess's doll and that *'she was doing that to the doll as well'*. She fell silent for three seconds on remembering this, and again when recalling that Jess used to bang her head. She added that she '*wondered in the first place, why she had been put there anyway*', and that she felt helpless in the situation.

When I tried to open up the subject of a child masturbating and what it might bring to mind, Amina was unable to think about it. She fell silent, her eyes reddened and I thought she was going to cry. She got side-tracked into telling me about a recent incident with another child.

She thought that what was known about Jess before placing her had been *'disregarded'*, that *'it was more about fitting people in anywhere'* rather than looking at '*implications for the carer and the family and the child*'. When I asked what she would have done differently, she replied that she *'definitely would not have placed Jess there'*. She said it would have been better to have met Jess sooner and to tackle the issue, but added that this was difficult due to her heavy workload.

Amina reflected that she knew the carer better now, knew her limitations, but said:

> *I think, em, in this job it's, it's you kinda know their limitations and then they get stretched all the time, you know, people ignore, em, those kind of boundaries.*

She added, with some conviction, '*and that's something I do not like*'.

Amina admitted that she didn't know what advice she gave to Kate, and that she herself had little experience in this area – *'I was new to it as well*'. Sadly, she did not feel that she had been able to fulfil her role as a supportive person: *'I wouldn't say I was able to, totally, no*'.

At the end of the interview, I left feeling that I had provided a thinking space for Amina, something which was obviously still required despite the time which had passed. This was confirmed by a comment she made on showing me out, *'I feel much lighter now*'. It was indeed as though she had unburdened herself of something. She needed to complain about the shortcomings and failures of the system, about things she objected to but felt powerless to do anything about.

4.5.5 Support

- Kate said that her SSWs were '*great*'. However, there was no evidence in the interview of any support other than advising her to take Jess to the GP and to keep a note of everything; as Kate said, '*everything I'd already done*'. She did not experience Martin as helpful, as she thought that he didn't '*realise*' or '*take in*' what she was saying.
- Martin felt supported by other professionals, with whom he discussed the case. He acknowledged his lack of experience and knowledge in the area of sexualised behaviour in children and said that he would have liked guidance, support and reassurance on the subject.
- Amina lamented the lack of support, supervision and training within her organisation. She said she would have liked some input on the subject of masturbation in children of this age.
- All three respondents in this case found themselves unable to be supportive. Both Kate and Amina acknowledged this. Somehow Martin, despite his wishes and attempts, was not experienced as supportive, as Kate clearly felt unheard by him in relation to her concerns about Jess, and felt let down by the lack of information provided.

4.5.6 Reflections

Kate described a worrying level of self-harm and aggression in Jess, but the masturbation seemed to take priority as the most worrying behaviour, or the most difficult to live with. The idea of sexual activity in such a young child raised strong feelings and was disturbing to hear. Kate could not bear the thought that the other children in her care might be harmed by Jess's behaviour, or that she could not protect them from it. Kate put aside her own thoughts and feelings about the situation and its effect on her. It was easier to talk about the effects on other children of Jess's behaviour than to talk about the impact on herself.

Like Case One, *how* Kate told her story revealed how much of an emotional impact the experience had on her, and how painful it was to think about and remember it. The way in which the story of Kate's time with Jess was revealed, either in an outpouring of words or not completing sentences and use of the second person, highlights the potentially overwhelming and traumatic nature of the experience. Her discomfort with talking about masturbation was reflected in her mispronunciation of the word, as though she was either unfamiliar with speaking it aloud, or that it was too awful to utter in connection with such a small child. Thinking about Jess masturbating led to awful thoughts: What does it mean? How does she know? Has she been sexually abused? Kate lacked a 'framework of meaning' (Eatough and Smith, 2006) to help her understand this behaviour, as did Martin and Amina, both of whom acknowledged a lack of experience in this area.

Feelings of discomfort and uncertainty were raised not only by Jess's behaviour but also by the unplanned nature of her arrival and the absence of information. The absence of information left Kate to grope about in the dark, as it were, trying her best to understand Jess.

Amina, too, was moved out of a familiar position into one of discomfort and uncertainty. Her interview was revealing in its honesty about her feelings towards her organisation, about which she eventually spoke frankly. The process revealed Amina's difficulty in staying on the subject of masturbation and Jess banging her head. On several occasions, she trailed off mid-sentence and fell into a distracted silence, her mind drifting off the subject. She shifted between a lack of confidence and vagueness about the issues at hand, and a clear and frank articulation of the organisational issues she saw as having contributed to the poor outcome for this placement.

This could be thought of as defences against the anxiety raised by thinking about the kinds of experiences Jess might have had, an example of defending against painful, anxiety-provoking thoughts. Bion's idea of minus K is relevant here (not thinking, evasion of psychic pain, turning away from truth).

There was a clear division or split between a beautiful and at times delightful child and a child with a fierce temper, filled with rage and apparently intent on hurting herself or others. Kate had to grapple with opposing states of mind and views, such as adorable/detestable, attractive/repellent, and placidity/violence. Such feelings, in both Kate and Jess, indicate a state of ambivalence, implying a lack of synthesis of feelings of love and hate, thought by Klein (1946: 3) to be necessary for the infant's emotional and intellectual development.

I turned to Winnicott's idea of transitional phenomena to help me to think about Jess, as her relationship with her doll was so striking. The doll had the quality of a transitional object in being 'an almost inseparable part of the infant' (Winnicott, 1951: 235). Winnicott's description of the transitional object is that 'it must survive instinctual loving, and also hating, and, if it be a feature, pure aggression' (1951: 233). Jess's use of the doll exemplified this, loving it at one moment and beating it the next.

The doll may give us a glimpse of Jess's early experiences, but her relationship with the doll is an attempt to work through those early experiences. Jess's feelings towards the doll mirror the confusing and ambivalent feelings which existed between Jess and Kate. Jess loved and hated the doll, much in the incongruent, paradoxical way that Kate described Jess in contradictory terms. Unlike Jess, who could enact her feelings via her doll, Kate had no such object on which to direct and process her complicated feelings. There was nowhere for Kate to take her disturbed thoughts and feelings. The absence of a containing experience for Kate meant that she was less able to provide containment for Jess.

The lack of opportunity to reflect on such disturbing, complicated and unwelcome emotions meant that, eleven months after the end of placement, there appeared to have been little or no working through of the experience for Kate and it remained largely undigested. Although it became possible to begin to think about the distress of the situation in the presence of another i.e. the researcher, this did not seem to have been possible, or available, at the time of the placement, or after the breakdown.

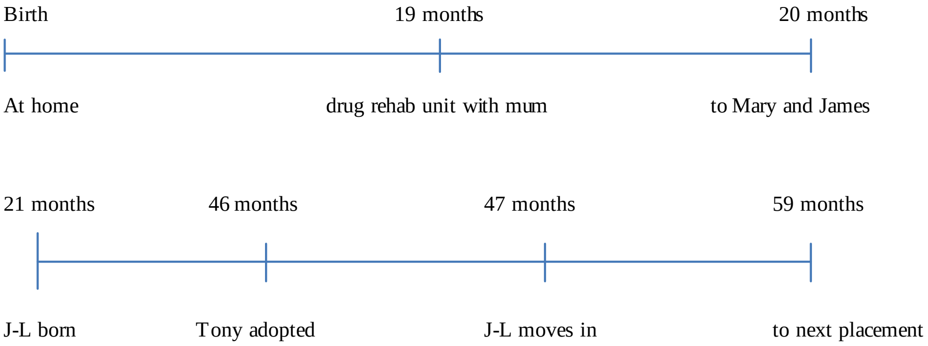
The experience of looking after Jess had been distressing and disturbing, and had left a lasting impression on Kate. Although she decided she could no longer care for Jess, her compassion for the child was obvious. What shone through the interview was how caring Kate was and how difficult her task had been. At the end of the interview, Kate put out her hand to shake my hand and I felt that I had given something to her, rather than the other way round.

4.6 CASE FIVE: CHELSEA

Carers: **Mary and James**
Child: **Chelsea**
Age at time of placement: **20 months**
Length of placement: **3 years 6 months**
Who interviewed: Mary
Where interviewed: carers’ home
Time between end of placement and interview: **6 weeks**
SW: **Nadia**
SSW: **Val**
Child’s sister: **Jamie-Lee**
Other foster child: **Tony**
Reason for breakdown: aggression

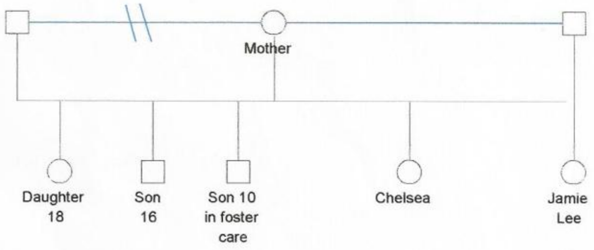
BOX 5

Timeline

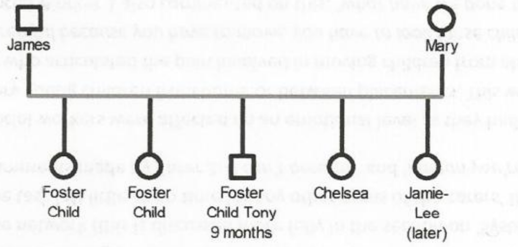


Genograms

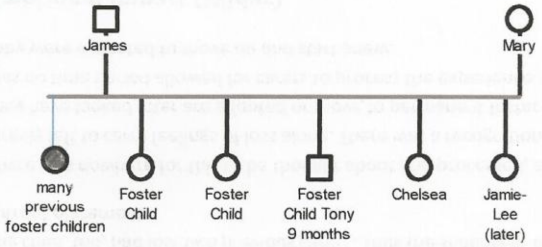
Genogram 1: Chelsea's family of origin



Genogram 2: In carers' house at time of Chelsea's placement



Genogram 3: In the mind of carers



4.6.1 Social Worker Interview

Background

Chelsea was the fourth child of her mother, first of her father. Mother's older three children were already accommodated by social services. Mum was described as a '*poly-drug user*' with a chaotic lifestyle, including frequent moves of house due to conflict with neighbours. On becoming pregnant with her next child, Jamie-Lee, mum entered a residential rehabilitation unit with Chelsea, for three weeks. On the day she left this accommodation, she was immediately using drugs again.

Chelsea was accommodated on that day and went straight to Mary and James's house. Jamie-Lee was born some months later and spent time in hospital withdrawing. She was then accommodated in a separate place and has never lived with her birth parents. Nadia had wanted her to go to the same placement as Chelsea but, at that time, Mary and James did not have a vacancy. Nadia said that adoption for both girls together was the plan, '*that's always been the plan*'.

When I asked Nadia what were her impressions of Chelsea, and to tell me what sort of girl she was, this was her reply:

> *em, because she was the only child at that point, you know, her mum kind of em doted on her, in different ways by, you know, lavishing em but, expensive clothes, shoes, but she would miss the basic care, you know, food, nappies and stuff like that, but she would go and buy a cake for £80 on her birthday, £40 worth of shoes, and she won't have money for anything else and that was a kind of pattern, so Chelsea was constantly hungry, and anything and everything she would just gorge on, you know, if she could manage to find, people offered her, she would just eat, stuff herself,*

Nadia described birth parents as '*quite loud*' and arguing often, and knew that Chelsea had witnessed this.

She said that mother was '*boisterous*' and '*threatening*' and that workers were reluctant to work with her. However, Nadia saw her also as '*likeable*' and '*like a child herself*'. Nadia was aware that mother had had a difficult childhood, including sexual abuse, and had spent time in foster care.

At this early point of the interview when I heard about Chelsea's birth parents, Nadia made links between their lifestyle and behaviour and Chelsea's behaviour:

> *She had been seeing the way mum and dad kind of interacted, in terms of them being quite loud and I think she picked that up as well, and the temper tantrums, she knew that was the only way she could get attention from both mum and dad, if they were, you know, totally off, a zone, you know, totally kind of knocked off by drugs or whatever, and probably that was the only way she could kinda, kicking and screaming, shouting,*

However, later, Nadia seemed to lose hold of these descriptions of serious neglect and negative interaction, and wanted to view Chelsea as a '*normal*' child who could be adopted into an ordinary family.

SSW Val also commented on Chelsea's home environment:

> *with drugs, poly-drug use, you know, I mean really, **really**. Eh, it would be hard core, definitely, you know, top of the range neglect coming from that house, absolutely, and she was there for eighteen months.*

As did Mary:

> *And apparently she was strapped in her pram all the time, em, food was thrown at her like a dog, and she never had toys and things.*

Placement

When I asked what were her concerns about Chelsea at the time, Nadia replied:

> *We didn't have any, actually, the placement was going very well and we were hoping, you know, em, that when Jamie-Lee did move things would em, we would progress with the adoption.*

And:

> *She was doing well, I mean we never had concerns.*

She described the carers doing well and coping with Chelsea's tantrums, and also described nice times with her. Nadia thought that Mary and James were '*brilliant*' carers and spoke highly of them several times: '*they are brilliant carers, there's no doubt about that*'. In fact, she wished that they would adopt Chelsea, '*because Chelsea had settled so well*'.

She described seeing Chelsea at contact with her parents, and when Mary went to leave, Chelsea cried and ran after her, showing a preference for Mary as her primary attachment figure.

Nadia did mention Chelsea's screaming, but it was not a major feature of the interview, as it was in Mary's account. Nadia said, '*she always had that screaming thing*', recalling how much it had affected her when she used to take Chelsea to the nursery, while she was living at the rehabilitation unit with her mother:

> *She would sit in the car and* ***scream****, scream, scream, literally, I mean you would think your head was going to burst, and that's how bad it was.*

The following extract, in response to my question, '*what do you like about Chelsea?*' highlights the complexity of Nadia's thoughts and feelings about Chelsea:

> *I think she is a normal child in every sense, except she has got attachment problems there, which obviously you know has not helped with whatever's happened over the years and I think we are partly to blame, we didn't find a family for her soon enough to move. She is a very loving child, I mean, and, a- she- when you see her, you know, I think people catch on to her quite easily, but it's only when, you*

> *know, when she displays that very controlling behaviour that people are put off…but I just don't see her as a different- any different from a normal child being brought up in a normal family.*

Throughout the interview, Nadia insisted that the sisters could live together and that what was being reported to her was within the realms of ordinary sibling rivalry. She said that everything had been going well with the contact between them, until the other foster child, Tony, moved out, and Jamie-Lee moved in, and then Chelsea '*picked on*' her.

Conflict between two agencies

Nadia's account of events highlighted the dispute which arose between her agency and the fostering agency. Nadia's plan was to have both girls adopted together, but the fostering agency thought that adoption together may not be the best or the only plan:

> Nadia: *They wanted to split them up and we said no, they had to go as a sibling group, and, and that's when they started coming back and saying, they're too difficult to place.*

Nadia said that she became aware that things were not going well only when the fostering agency began their assessment of the two siblings, in order to make an informed decision about long-term placement. She expressed a view that Chelsea was '*probably confused*' when the assessment team started going in, and she assumed that they would be telling her, '*you're going to get new mum and dad and stuff like that*', something she would not have done until they had identified a placement. She was sure that Chelsea *'was getting the message that, you know, she's not going to be there*' (i.e. with Mary and James).

She expressed more anger as the interview went on, and said that the fostering agency started their assessment from a basis of '*these two children are difficult to place*', which she felt was wrong and unfair. She broke off, mid-sentence, when talking about this:

> *And that, I think, is the whole thing that-* (breaks off with a sound of frustration)

She strongly felt that people were just concentrating '*on the negatives*' and that this was jeopardising Chelsea's chances for adoption. She felt that the fostering agency '*tried to make it out worse than it actually is*' and said that '*these two girls are not the worst I've seen*'.

However, her own feelings of guilt and responsibility were clear from the following extract:

> *It's just sad that, you know, we as workers are trying to kind of, you know, em, mess about with these two children's lives because of what we have* ***not*** *done,*

She said that the case became a '*mess*' and that someone was responsible for that, adding angrily that the fostering agency had said her service was to blame for not completing essential forms on time.

At the end of the interview, she became reflective and was able to step briefly outside the conflict. She recognised that things would have been better had Jamie-Lee been placed beside Chelsea from when she left the hospital:

> *And that would probably have made the difference for Chelsea, that her sister's there, you know, she will have seen her sister from baby,*

This, then, is an acknowledgement that the timing of placing Jamie-Lee with Chelsea may have been unhelpful, if not actually ill-advised. Nadia reflected that she saw no '*major difficult behaviours*', but that '*now we have created one*', and that Chelsea is now '*damaged*'. She summed up her views thus:

> *What was pretty straightforward case has now become such a mess.*

4.6.2 Carer Interview

Introduction

Mary was a carer who loved children. She had had five children of her own and had been a carer for ten years. She had fostered many children before Chelsea arrived. Despite the difficulties of this placement and the fact that it broke down, she had not been put off fostering, '*I still love my job*'.

Screaming: an urgent communication

When I asked Mary if Chelsea moved into her home on a planned basis she replied, '*no, she came in an emergency*'. The very word, '*emergency*' strikes fear and alarm and brought to my mind the scream or wail of sirens.

Mary told me that Chelsea couldn't talk when she arrived, '*it was just pointing and screaming*'. Her screaming was referred to frequently throughout the interview and I had a picture of a house and car filled with screaming. At various times, Mary called it '*excited*' screaming, '*a happy scream*', and '*constant high-pitched screaming*'. When I asked her for her first impressions of Chelsea, she replied:

> *Screaming. Not crying. It was an excited scream. And she had a little pram. And she just, everywhere in the house, banging off walls, screaming, it wasn't an upset scream, just- a happy scream, that was away up there the screaming.*

This description made me think of a child who has not had an experience of containment, and needs the hard concrete walls to get an experience of this.

The noise of the screaming, and the apparent relentlessness of it, made me wonder how it could be tolerated. However, when I suggested that the screaming would '*drive you up the wall*', Mary said '*no, no*', that they expect children to come in '*troubled*'. I wonder now at my somewhat leading or suggestive phrase, and if the intolerability of the screaming was being projected into me.

Mary described a car journey of over an hour's duration, when Chelsea '*screamed the whole journey home. Not a tear, this high-pitched screaming*'. Her husband was the one who always drove the car and Mary later said that she did not know how her husband drove the car, '*with all the screaming going on*'.

To begin with, it was '*very, very hard*' to get Chelsea into a routine. For example, the sleeping routine was:

> *Very difficult, because you put her down and she would scream and scream and scream. We had to keep her in a travel cot, eh cos you couldn't put her into bed cos she'd be right back out the bed again, and if she was near a wall she would rip the paper off.*

Mary felt that Chelsea '*just wanted the attention all the time*' and that '*she would scream for it and scream for it*'. Although '*she did start to get a wee bit better*' and the screaming became less frequent, she still screamed for things, right up until the end of the placement. Mary spoke of the need for '*attention*' several times; however, I would think of it as a need to be held and to feel understood – perhaps this is what she meant by her use of the word.

Chelsea sought care and nurture from Mary – '*she craved it*' - and was able to accept it, but she very quickly resorted to screaming when it was not being provided directly:

> *She liked you to sit her on your knee and stroke her arms, she loved all that. But as soon as that was over and done with – back* (i.e. to screaming).

In answer to my question as to what was the most difficult thing for her, she replied without hesitation, '*the screaming, the high-pitched screaming*'.

Loss of 'special' relationship

Mary described Chelsea as having made a '*special bond*' with Tony and being '*very very close to Tony*'. She gave a description of them playing together happily on the living room floor, and said that Chelsea never hit or hurt Tony. They were together in the placement for twenty-six months, at which time Tony was adopted by another family.

Mary was intensely aware of the loss Chelsea felt when Tony left:

> Mary: *She kept saying, 'where's Tony?' She fretted for Tony.*
> Researcher*: did she? So she really missed him?*
> Mary*: oh, terrible.*

She returned to it later in the interview:

> *There was hardly a day went by, she would ask for Tony all the time.*

Her experience of Chelsea's loss was felt in the silences when the subject came up again towards the end of the interview, first with a five-second silence when she confirmed that Chelsea missed Tony, and then a nineteen-second silence when she reflected on how close Chelsea was to Tony.

Departures and arrivals

Hot on the heels of Tony's departure was the arrival of Jamie-Lee. These were the two events which Mary thought had a significant impact on Chelsea and on the stability of the placement.

Mary acknowledged how difficult the screaming was to live with, but it wasn't the issue which she said caused the breakdown. She clearly placed the breakdown in the context of Tony's departure and Jamie-Lee's arrival. She referred to this several times throughout the interview:

> *But once Tony moved out in the December and her wee sister came in, that's when she went right downhill again.*

And:

> *It just seemed to stem when the sister came in, when Tony went out and the sister came in.*

And finally, towards the end of the interview:

> *It's when Tony moved, and the wee sister moved in…that was…that was it.*

The sibling relationship: from delight to shock

Chelsea and Jamie-Lee had regular contact together in the year before Jamie-Lee moved in, and everyone agreed that it went well and that the girls should be together. Mary said that '*they were happy with the way they bonded'* during visits and that Chelsea '*was so excited for her sister to come*'. Val confirmed this in her interview. However, both Mary and Val spoke about how shocked they were at what followed when the girls were living in the same house.

Mary described a fierce envy of Jamie-Lee and how unbearable it was to Chelsea to see Jamie-Lee receiving affection from her:

> *She loved story time, just…involving her, it's a close contact with her, you know, sitting her on your knee and things like that. But if I had to put Jamie-Lee on my knee she would go daft, she would go daft,*

Mary said that '*she couldn't stand her wee sister*' and that she couldn't leave them alone as Chelsea would hit her all the time. She revealed a more worrying thought about Chelsea's moral development when she said that she thought Chelsea was aware that she was hurting Jamie-Lee:

> *She knows what she's doing, she's planned- you know, she knows what she's doing,*

Mary regularly called Nadia and updated her on the difficulties in the relationship, and the struggle she had to manage it.

Emotional Impact of Looking After Child

One of the themes of this interview was the need to mute the emotional impact of the experience. The following section goes into some detail about this.

Self-protection

The interview is filled with references to Chelsea's screaming and how '*constant*' it was. However, there was a process of normalising the screaming, or of denying the harmfulness of it. When I suggested that '*it sounds quite wearing?*' Mary replied,

> *Well, me and my family have talked about it, it became normal, you got used to it, kinda blocked out the screaming,*

Later she said:

> *It was, what we were going through, as I say, it ended up kinda normal to us, we were that used to it going on.*

She described how she and her family learned to dissociate from it:

> *We all learned to block it off, as I say it was like a normal thing, used to learn to block it, you know,*

'A Military Thing'

Mary described a pragmatic approach where they had to '*just get up and deal with it and get on with it*', and a regimented routine in order to accomplish ordinary tasks and prevent Chelsea from hitting her sister. For example:

> *If I was in the kitchen I would say to James to stay here, or vice versa, or we're going upstairs, it was like a military thing, she couldn't be on her own,*

In other words, using order and tight structures to maintain something resembling an ordinary family life and not to be drawn into the violent and destructive world of Chelsea, arising from a failure in early containment, feelings of loss and rejection, and the experience of early abuse.

Secondary Trauma

When Mary told me about the respite periods which Chelsea had, she said that the respite carers refused to have Chelsea back. One of the respite carers had said, '*in all her experience, she's never known a child that wouldn't back down*'. Of another respite carer, Mary said that she was '*traumatised*'. I asked her to explain what she meant by that and she replied that '*she was so exhausted*'. Mary was projecting her own trauma into the respite carer. She seemed to realise this when she added, '*it was what we were going through*'.

She said on two separate occasions, that it was only once Chelsea had gone that they realised '*what we did go through*'. Finally, she said:

> *as I said, now we're seeing the difference. I wouldn't do it again.*

There were a few occasions when Mary did acknowledge the emotional impact of the situation. She said that during the first period of respite they went on holiday and '*we really needed it*'. In the end, it was her daughter who helped her to see just how difficult things were, and the lack of progress, when she pointed out how long it had been since Chelsea had arrived and how little had changed. They had planned to go on an annual holiday together but her daughter said she wouldn't go, because the previous holiday had been so trying due to Chelsea's behaviour:

> *Every day she was just kicking off, it wasn't a holiday anymore.*

It was only with hindsight that Mary was able to see how challenging it had been, how much they had blocked out, and that it was not ‘*normal*’.

Loss

Late in the interview, as mentioned above, Mary was in touch with Chelsea’s loss when she fell silent for two periods. She may also have been in touch with her own loss, not only of Chelsea but of Jamie-Lee and Tony too. However, this was not openly acknowledged by Mary as a significant issue.

Compassion

Mary admitted to feelings of hopelessness and helplessness, but only on one occasion: ‘*Tired at times, sometimes really tired, sitting, what do I do next?*’ Several times throughout, Mary quietly made reference to Chelsea’s early experiences, showing sensitivity and understanding of why she was behaving as she was. Directly after telling me how Chelsea would snatch toys from her sister, she said, ‘*but apparently she had no toys or anything*’, and later, ‘*she never had anything at the beginning*’. She said that she ‘*felt sorry*’ for her and:

> *when you look in her wee eyes, she’s hurt, that wee hurt look in her eyes, you know*

Looking back: regret and resentment

Mary regretted having to give up on Chelsea and felt resentful that nothing was done to help her and Chelsea to maintain the placement. Despite this, she remained dedicated to fostering and said that if she found herself in a similar situation she would ‘*recognise it straight away at the beginning*’ and ‘*fight at the beginning*’. This theme is repeated throughout the interview:

> *But I always say if she had help from the beginning there would’ve been a big difference in her,*

And:

> *But if the help was there at the beginning Chelsea would have*…(stops)

When I asked her what if anything she would have done differently, she replied:

> Mary*: fought for help at the beginning.*
> Researcher*: right, right.*
> Mary*: and I've said to everybody, if Chelsea had got help, and helped us to help her, there would have been a big difference in her.*

4.6.3 Process of the interview

Mary's account was subdued and did not overflow with detail in the way that most of the other interviews did. I did not realise at the time just how nervous about the interview she was. It was during the analysis and reflection that this became more apparent. She struggled through the first half of the interview with a dry throat and her voice croaking and, as I was in her home, I didn't feel I could offer her a drink. It wasn't until she said '*sorry, tickly throat*' that I was able to suggest she could get herself a drink.

This awkwardness mirrored the discomfort and anxiety in the caregiving situation. Mary could see Chelsea's distress on Tony's departure and the arrival of Jamie-Lee but felt helpless to do anything about it. The dry throat indicated unexpressed or stifled emotion; I felt that Mary wanted to cry but somehow could not. I commented in my reflective notes after the interview on how little expressed emotion there was during the interview, this being particularly noticeable in a placement that had lasted for three-and-a-half years, and which had ended only six weeks before the interview.

I recall experiencing some of the guilt and disappointment that this child was not provided with therapeutic input. Mary frequently mentioned the need for psychological help for Chelsea which was not provided when it was most needed. I felt guilty and frustrated that I had not been able to provide such help; instead I was in the role of interviewer/researcher, asking questions about breakdown.

4.6.4 SSW Interview

Introduction

As Val's interview was so rich in detail and gives such a vivid picture of Chelsea, I am providing a full account of her interview rather than just a summary.

Val had been working with Mary and James for five years and felt that she knew them well and had a good working relationship with them. She spoke highly of them throughout the interview:

> *I know them very, very well*;
>
> *a good working relationship*;
>
> *I feel I know them inside out*;

And:

> *they do what it says on the tin. They're stable, just the warm, very nurturing people who are tried and tested, so I feel I've got a good relationship with them. An open and honest relationship where we can put stuff on the table,*

Val said that Mary and James were not eloquent people, '*they're not very articulate people*', and that she was often the one to speak up on their behalf.

Screaming: an urgent communication

When I asked Val what she remembered about Chelsea when she arrived, she remembered the screaming:

> *I remember the screaming and thinking* (draws breath in, in dismay) *how can a wee tot like that scream so much*

And:

> *But the screaming could go on for so long that I thought, how can she actually maintain that?*

She gave her opinion as to where she thought this screaming had come from:

> *That's what she's- that's the only response that she's been able to make in the community living with her parents, you know, and when I've met them subsequently then the jigsaw comes into place.*

The Sibling Relationship: from delight to shock

Like Mary, Val was observant of the relationship between the two sisters, seeing the arrival of Jamie-Lee and Chelsea's feelings and behaviour towards her as the '*catalyst*' for the breakdown. She was in touch with the pain of witnessing Chelsea's intolerance of Jamie-Lee. She spoke of the shock and surprise everyone experienced when things turned out as they did, as it had not been predicted or expected from Chelsea's behaviour towards Jamie-Lee before this time. She used the same word as Mary did to describe what it was like to witness: '*it's been horrible to watch with her own sister*'.

Val, like Mary, commented on what she saw as the intent to hurt:

> *I know this sounds terrible for a five-year-old wee lassie, but she goes out her way to hurt Jamie-Lee,*

I asked her to give me an example and she described a time when Chelsea was refusing to share her toys with Jamie-Lee. Val encouraged her to bring some of her toys from her room, to share with her sister. Chelsea's reaction to this was to look suspiciously and angrily at Val and then to fetch the smallest toy she could find, '*a wee dog and it was the size of your thumb*'. Shortly, Chelsea took the small toy back to her room and then, when Jamie-Lee went to the door, Chelsea ran up and tried to shut her fingers in the door, '*and missed wee Jamie-Lee's fingers by an inch*'. Val said:

> *God forgive me, can I use a word like hatred? It seemed like- the hatred towards that wean*[6] *was, you know, it was there,*

Later in the interview, Val used the word '*corporate*':

> *It was like a corporate, it was like a decision, she was making decisions, to hurt her sister,*

I think what Val meant here is that Chelsea's actions were pre-meditated, planned and deliberate, and Val was concerned about the implications for her moral development. She later said that *'the intent got to me*'.

Everyone was '*shocked*' at this, not having expected it from the visits between the sisters before Jamie-Lee moved in, and from Chelsea's positive relationship with Tony. She described feelings of '*delight*' when everything went so well with the sibling contact, followed by shock when it went so badly wrong: '*shocked isn't the word. We were shocked*.'

Val said that the carers were upset at how much it was affecting Jamie-Lee who was '*miserable*'. She backed this up with a memory of her own when she saw Jamie-Lee looking terrified:

> *I seen Jamie-Lee quivering as her sister went by her, one day I was in visiting, she quivered like a jelly. That's awful to watch.*

She described Mary's despair:

> *I remember I said to Mary, how do you feel about Chelsea? And her words was, she says, I feel so sorry for her, she says that we can do nothing more for her, and she says, and I don't know who could when she's with her sister, to break that cycle of what's going on.*

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[6] Glasgow word for a small child

When Mary began saying that they may not be able to continue, Val knew that something was seriously wrong:

> *Mary was just saying to me, I don't know how long we can continue and I thought, I need to listen here, cos these are tried and tested carers. Very good…but this was something and I thought, if they can't do it, I'm really worried about this.*

I asked Val if she had any ideas of how to explain this behaviour in Chelsea:

> *Nadia said it was sibling rivalry. And I went, there's no way that's sibling rivalry. I know that. Now, I can, I can exclude that and so can Mary. There's absolutely no way.*

She then went on, going through a few possibilities, wondering if it was because she was a girl, or if it triggered memories of home, but added that it couldn't be that because the girls were never together at home. She was clearly puzzled and struggling to understand Chelsea's intense feelings and behaviour towards her sister.

Conflict between two agencies

Val acknowledged the disagreement between her service and the area team. In fact, she named the conflict as the issue which made her task more difficult. Despite this, she wanted to emphasise a good working relationship with Nadia, who she described as '*fabulous*'. She had frequent communication with Nadia and her manager. However, as Val said:

> *But obviously when you're thinking one thing and they're thinking another, that isn't good news.*

Val told me how she asked the respite carer to write everything down, as though to gather evidence to support or refute her view:

> *Are you up for a weekend here, and I says could you please write it all down. I went, because there's a bit of…in here, the area team are saying these children are perfectly*

> (stumbles slightly over the word so repeats it clearly) *perfectly adoptable* ***together,*** *and there's a different kinda view, from the carers, that they think Jamie-Lee's life is being made miserable by her sister, and so there's a bit of conflict, could you write it all down,*

This highlights the seriousness of a situation where professionals are thinking two different things, leading to a split in the system which has direct consequences, in this case, for two children. It also had consequences for Mary, who began to doubt herself due to Nadia's different view: '*I was questioning myself*'.

Twice, Val used the phrase '*shouted from the rooftops*' when describing how much the area team wanted the two girls to remain together, as if to emphasise how firmly they held onto their view and how difficult it was to have a different view and to put this to them. From her perspective, it was as though the area team were unable to see beyond the principle of keeping siblings together, but to Val and Mary this was an unworkable plan. '*They weren't listening*' – they had one plan and they were sticking to it and seemed unable to consider any other possibility.

4.6.5 Support

- Mary described a supportive relationship with Val, one of trust and respect which had developed over the five years.
- Although Val provided a high level of practical support, and possibly emotional support to Mary and James, neither she nor Nadia helped directly in relation to thinking about Chelsea's emotional needs and psychological disturbance.
- Nadia had no support or regular supervision for herself. There had been a manager whom she'd found helpful, but she left. She was, therefore, largely left to carry her feelings of guilt and blame alone.
- Val felt supported within her own agency.

4.6.6 Reflections

This interview took place shortly after the breakdown. Mary was going through a mourning process and the experience was still raw. This raises questions about the significance of the timing of the interview, and how different it might have been at a later time.

The material gave clear expression to the urgency of Chelsea's communication with her prolonged and constant screaming. It conveyed the critical, urgent nature of Chelsea's internal state. Chelsea communicated a painful emotional state, a terrified and primitive state of mind, mainly by evacuation (excessive use of projective identification, see Bion, 1962, Rosenfeld, 1987 and Joseph, 1987). Both Mary and Val conveyed the horror of watching a child hating and hurting her sister and feeling helpless to do anything about it.

Mary understood just how much Chelsea was affected by the departure of Tony and the arrival of her sister. She was in touch with Chelsea's loss of Tony and missing him every day; having experienced a loss (of Tony) herself she could easily empathise with Chelsea's loss. Neither Chelsea nor Mary had time to process the loss of Tony, as Jamie-Lee moved in approximately one month after Tony left. In fact, I never heard how Mary felt about Tony's departure as she only spoke about Chelsea's experience of this loss. Were some of her own feelings of loss displaced onto Chelsea? Did she, like Chelsea, struggle to accept the arrival of another child on the heels of Tony's departure?

The experience of the loss of Tony, and feeling usurped by her sister as Mary's foster child, alongside Chelsea's early adverse experiences, combined to produce an unbearably painful situation. There had been a massive failure in containment and a breakdown in the capacity to bear painful emotional states. The carers defended themselves against the experience by muting it, blocking out the screaming. To be open to the full impact of it would be unbearable.

Something got polarised in Mary's and Val's different styles of reporting the experience with Mary's paucity of description and Val's effusive account. Val was a colourful speaker who illustrated her account with examples which painted a vivid picture of what life with Chelsea was like. This was in stark contrast to the carer's somewhat subdued account. While this could be partly explained by their individual styles, it was also an indication of the emotional impact of living with this particular child, in these particular circumstances, and of the impact of loss. Val was able to provide the verbal account which Mary was not, perhaps because she was at a distance from the relationship, therefore it was easier for her to talk about it. Both Val and I expressed some of the stifled or unexpressed emotion; me with my '*drive you up the wall*' comment, and Val in her effusive and detailed account.

Mary and Val were able to talk about Chelsea's disturbing behaviour and the '*hard core*' neglect she had experienced, but this was more difficult for Nadia. The SW team were holding onto one idea - that these siblings should be together, no matter what. In order to hold onto this view it was necessary to overlook not only Chelsea's experiences but also the experience of Mary and James in trying to care for the two girls, although this was not done consciously. This led to a sense of something being unbending or inflexible. Nadia simply wanted the girls to be adopted, she didn't want to emphasise any of the issues and problems which existed, rather she wanted to paint a positive picture to increase their chances of adoption. The crux of the dilemma for Nadia was a fear that if Chelsea's disturbance and need for specialist help was acknowledged it would jeopardise her chances of being adopted.

Nadia's interview revealed her anger about the dispute with the fostering agency. Her task was to find an adoptive placement for Chelsea; the fostering agency's task was about matching their carer or adoptive parent with the child. Both wanted to avoid placement breakdown but each had a different emphasis. This seems to have led to a situation where only one side of the story could be seen by each party: Nadia seeing the ordinary aspects of the child, the fostering agency seeing Chelsea's emotionally disturbed and disturbing behaviour. Woodhouse and Pengelly (1991: 223) write of the ‘emotional pressure to ‘take sides’’, and losing sight of the system as a whole.

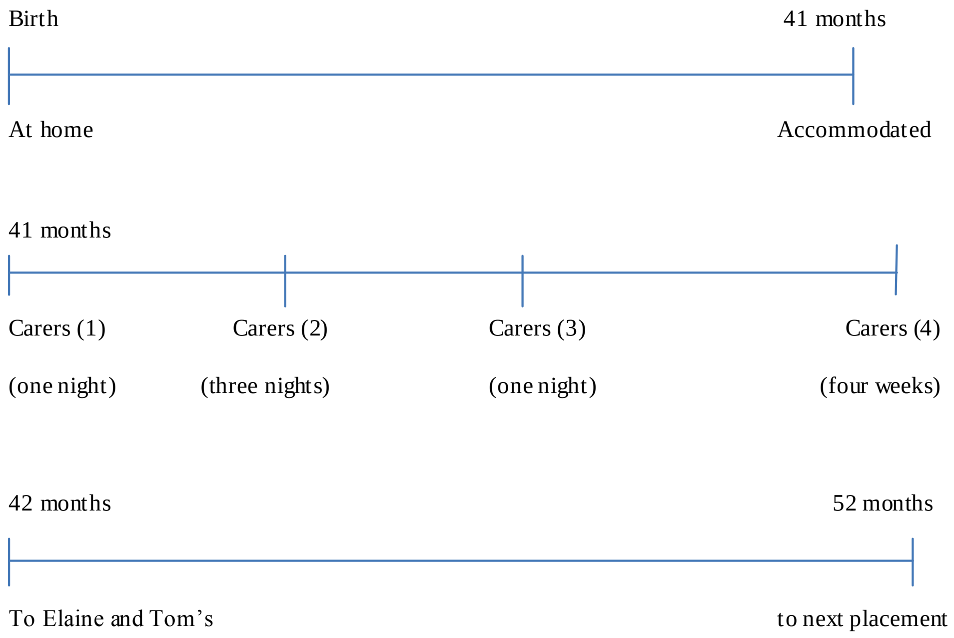
Despite this experience, and the placement ending in breakdown, Mary still loved her job and her dedication to and love of children was not undermined by it. The pre-existing and positive working relationship which Val had with Mary and James, with a level of trust built up over five years, allowed her to support them when things got difficult, in a way that would not have been possible otherwise. Although Mary did not feel any more skilled to deal with a similar child in the future, the experience gave her increased confidence as she knew what she would do to get the right input for the child i.e. ‘*fight from the start*’.

4.7 CASE SIX: JACK

Carers: **Elaine and Tom**
Child: **Jack**
Age at time of placement: **42 months**
Length of placement: **ten months**
Who interviewed: Elaine and Tom
Where interviewed: at their home
Time lapse between end of placement and interview: **ten months**
SW: **Scott**
SSW: **Heather**
Reason for breakdown: child’s constantly challenging and extreme behaviour.

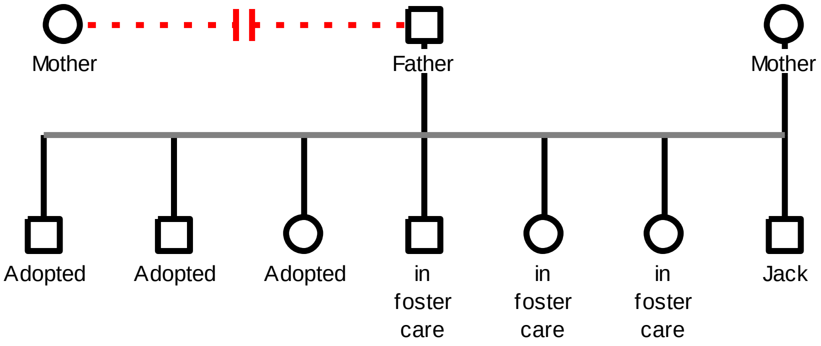
Box 6

Timeline

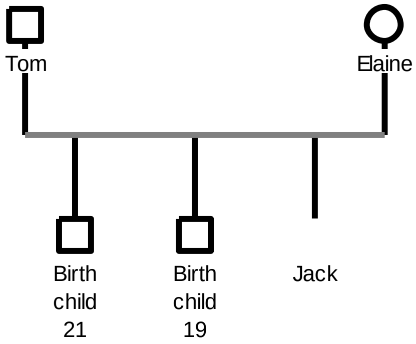


Genograms

Genogram 1: Jack’s family of origin



Genogram 2: In carers’ house at time of Jack’s placement



4.7.1 Social Worker Interview

Background

Scott was a social worker with nine years' experience. He had been working with Jack and his family for six months before Jack was accommodated. Elaine and Tom were Jack's fifth placement, with two of these placements lasting only one night, and one of them a weekend. The fourth set of carers agreed to keep Jack for four weeks and this allowed some time for a placement to be identified and for limited planning and preparation to take place. The social work department could identify no carers from within their own fostering agency and had to purchase a placement from an external agency.

Jack was the seventh child of his parents. His father had three children from another relationship, all of whom were by now adults and who had been adopted in childhood. Jack's parents had four children together, three of whom were already in long-term foster care. Jack did not know any of his siblings. Scott did not say why Jack was allowed to remain at home for over three years.

Jack's mum had been accommodated as a child and suffered from depression. Like Jack, mum had epilepsy. Scott was concerned about the parenting capacity of both parents, but gave more details about mum's limitations:

> *And that kind of positive interaction cycle wasn't- was absent, you know, there was no eye contact, eh, the physical handling of Jack was really…you know, like, she would hold him by the arm and be facing the opposite way and Jack would be…shouting or…eh, wriggling to get free from her.*

He said that mum used to strap Jack into his buggy all the time, or else physically restrain him. Scott remembered that Jack used to gorge himself until he was sick.

Scott said that Jack was accommodated due to '*cumulative physical neglect concerns*'. He was on the Child Protection Register for physical neglect and there were a number of agencies involved to support the family; however, they were unable to effect any change. Following a prolonged epileptic seizure, when Jack was admitted to hospital, a bite mark was discovered on his inner thigh:

> *nobody was ever charged for that but it was proven to be a schedule one injury, eh, through the court.*

Scott provided a grim picture of the family home, despite having just moved to a new house:

> Scott*: almost immediately that they moved the house was…disgusting I think is probably the best way to describe it,*
> Researcher*: really? Right.*
> Scott*: you would open the kitchen door, and they had a paddling pool in the kitchen which they used as a bin, to throw in like empty pot noodles, or used fast food trays and stuff, it was absolutely disgusting,*

Despite the descriptions Scott gave of the physical condition of the home, mum's parenting style, and the family history, the initial plan was for rehabilitation. This only altered once the Family Assessment and Contact Service had completed their assessment and recommended permanent foster care. Scott tried to have contact with parents reduced, but was always thwarted in this by the Children's Panel, and so it continued on a once-weekly basis.

Scott said that Jack had '*really complex needs*' and '*delays in most aspects of his development*'. He described him as '*clumsy*' and '*accident prone*'. He was also an unusually large child for his age. The words '*hyperactive*' and '*aggressive*' came up several times when Scott was talking about Jack. He said that he was '*lively beyond description'* and '*always on hyper*'.

Placement

Scott spoke highly of Elaine and Tom and the level of care they provided:

> Scott: *I think it was an affectionate relationship eh, they- they- particularly Elaine was a nurturing personality, really warm eh soft spoken eh nurturing person for Jack, and Jack would respond to her,*
> Researcher: *mmn hmmn*
> Scott: *my own observations and was fond of Elaine as well, so it was quite a warm, loving type relationship that he was experiencing,*

He described a warm and playful atmosphere in the home, individualised for Jack, despite the level of supervision he required. Scott said that he himself always had *'a really positive working relationship with the carers*'. He could see, however, the strain on Elaine and Tom of the constant demands of looking after Jack: '*as time went on, it was clear that it was affecting them*'. Scott said they were '*completely burnt out*' and had no ordinary life. He described noticing a '*defeatist*' tone of voice in Elaine, something which had not been there at the outset.

Scott thought that if Elaine and Tom had had the kind of support which the current carers were receiving (approximately three days per month of residential care) then it would have been a '*massive support*' for them. Scott felt angry, although this was expressed only mildly, that the external fostering agency, for which his organisation '*was paying quite an inordinate amount of money*', did not provide respite care for Jack and the carers. He thought that:

> *in hindsight there's a possibility that – that maybe we should have went through our own referral process to identify a residential respite.*

When Jack left Elaine and Tom's, he went to a residential unit for a few days and then onto another set of foster carers. Scott made a comment about the absence of any apparent separation anxiety when Jack left Elaine and Tom's. There was '*no visible distress*' and '*he just went there quite happily*'. He said that Elaine and Tom were '*devastated*' when they made the decision that they could not go on looking after Jack.

4.7.2 Carer Interview

Introduction

Elaine and Tom were a warm and relaxed couple, with a friendly and welcoming home atmosphere. They had been foster carers for more than three years but had fostered only one child before Jack. They had raised two children of their own. Their understanding was that they would look after Jack for six weeks, yet he remained with them for ten months. They were shocked and puzzled that no assessment had been completed and that this was only beginning to happen as Jack was leaving their care, by which time it was too late.

Their interview was memorable for the amount of laughter it contained. This laughter was tempered by the deep sadness they both felt at having had to give up on Jack. In fact, I was asked by Heather to hold off for a month or two before doing the interview, as they were still so upset by his departure.

Living in the whirlwind

Elaine and Tom had received little information about Jack. They were told that he had epilepsy and global developmental delay, but there was no mention of '*severe behaviour problems*'. Tom recalled that they were told '*maybe he could be a bit of a handful*', which was a serious under-statement, as the interview revealed.

They described a scene of mayhem when Elaine took Jack to register him with the GP, when she'd had to phone Tom to come and help her. Jack had '*escaped*' and was running around the surgery, pulling out computer wires, even managing to set off the panic alarm. It took three adults to pull Jack out from under a table.

Jack thought that everything was a '*joke*' and a '*game*'. He laughed at time out:

> Tom: *He just used to laugh at you and shout 'time out' and then run away.*

Tom and Elaine both remarked on how strong Jack was. Apparently, he was a large child, wearing clothes for a 7-8 year old, and he seemed to have an extraordinary strength:

> Tom*: strong as…*
> Elaine*: oh strong as…! Honestly,*

Tom added that three times Jack pulled off the post holding up the breakfast bar. Later, they told me how Jack had pushed the sofa across the floor, with Tom's mother sitting on it. This strength applied also to his blows:

> Tom*: if he gave you a wallop –*
> Elaine*: you felt it,*
> Tom*: you knew all about it.*

Tom and Elaine laughed hard at these memories.

The reality of having Jack in their home was far removed from the expectations they had before he arrived:

> Tom*: this wee three-year-old, you know, we thought it would be quite good fun, over Christmas and stuff like that, you know?*

Elaine added: '*we didn't, didn't know the half of it really, to be honest with you*'. They demonstrated how they were left feeling lost for words in the following exchange, which followed my question '*what did you like about him?*':

> Tom*: the stuff he got up to, he was just…wasn't he not?*
> Elaine*: oh it was, it was just…*
> Tom*: he just, he really was…*
> Elaine: (laughs)

Elaine told me that she lost two stones in weight in the time Jack was with them. They had been warned about this by the previous carer, and the respite carer had apparently lost eight pounds in the week he had Jack.

Elaine and Tom described Jack as an '*affectionate wee boy*' but his affection was not restricted to them – '*I mean he'd cuddle anybody, basically, not just us*'. Jack's unpredictability, and his confusion about how to express affection in relationships was evident in the following quote:

> Elaine*: he would cuddle you one minute and then punch you the next.*

Transformed lives: turning a home into a prison

The biggest concern the carers had was Jack's lack of any sense of danger and his constant risky behaviour. When they got up on the first morning with Jack, '*it was like Bedlam*':

> Tom*: I mean he just was into absolutely everything, throwing everything and…just…*
> Elaine*: we had to clear everything,*
> Tom*: we had to clear* ***everything,***
> Elaine*: we had gates up, em, he eventually could get over gates, em, so we had to put a wee snib*[7] *on the door and we had to zone off that* (indicating kitchen area)
> Tom*: we had nothing like this here* (indicating general household objects and ornaments).

Their descriptions brought to mind the controlled environment like that seen in a secure unit for acting out teenagers where everything is removed from the environment to make it safe. Jack turned on the gas, pulled everything out of the fridge, and tried to climb inside the washing machine. The physical appearance of their home was transformed, with the window blinds taken down, no mirror, no pictures or ornaments. I was reminded of something wild and untame, on the loose, bent on causing destruction, swinging from blinds and window handles, throwing hot drinks if he could get hold of them. If anyone came to visit, it was like entering a prison:

> Tom*: and he was just in about everybody pulling their jewellery, their earrings -*

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[7] Small lock

> Elaine*: aye, you had to take everything- everybody's bag had to go over there* (points to a high shelf) *earrings off, watch, beads, oh you had to watch,*
> Tom*: aye. And they all went into this secure…* (indicating safe place too high for Jack to reach*)*

It was a twenty-four hour observation, '*you had to watch him, couldn't take your eyes off him, basically*'. They said that '*escape*' was his '*mission*'. Elaine and Tom were able to do some ordinary things with Jack, like take him to the park or to their caravan, but they had to be constantly vigilant as it was always risky: '*once he got a wee bit of freedom he was off*'.

Going to the supermarket was a '*nightmare*', because he would kick out at everyone they passed, as was traveling in the car. They had to use three safety belts to try to keep Jack in, but '*he was like Houdini*'. At home, they had to be careful which toys they gave him:

> Elaine*: you had to really watch with toys because it was like a firing, you couldn't give him anything too heavy, cos it would be off the back of your head,*
> Tom*: aye, everything was a missile. Everything.*

This meant they had to deprive him of the very things he needed, but could not yet use, to help him to develop and to learn.

Elaine recalled that, at his mum's, Jack was '*strapped into a push chair all day'*. She also described something which Jack used to do to her, giving her the experience of being trapped, imprisoned:

> Elaine*: he used to put- didn't he used to put his two legs round my ankles* (holds out her legs to demonstrate) *right? And honestly, I couldn't move, it was like a vice, cos he was so strong, wasn't he?*

More restrictions on Jack's unbounded desires were required in the area of food. Tom told me that Jack '*just loved his food*' and that he was '*a great eater*'. However, he then added that '*he would eat all day every day if you let him*'. I remembered Scott telling me about how Jack used to gorge food and thought that Elaine and Tom may not have known that. At times, they used food to pacify Jack, for example when travelling in the car or watching a DVD, if he had a snack he would remain quiet for that time. Elaine wondered if Jack's mum had given him food '*to shut him up or something*'.

They were in a state of '*constant worry*', perpetually afraid that Jack would come to harm and that they wouldn't be able to keep him safe. They were '*totally worn out*' in their attempts to do so.

Elaine reflected on how their own lives were affected as a family in the following comment:

> Elaine*: we realised, three months before the placement ended, we thought, we can't go on like this, do you know what I mean, cos it wasn't any life, really. Even the boys couldn't bring friends in or, do you know what I mean?*

This comment '*it wasn't any life*' highlights how their lives were transformed from the life they were used to.

Drift

No decision was made that Jack would stay beyond six weeks, '*it just drifted on really, didn't it?*' Tom said that they were *'left to believe*' that there was nowhere else for Jack to go. There was an absence of any clear thinking and decision making, and apparently no discussion. Elaine and Tom were tentative in their decision to hold onto him:

> Elaine*: we thought, you know, come on, d'you know what I mean, we'll give him a wee chance,*
> Tom*: we'll try and – we'll just carry on and see what happens,*

Tentative and ad hoc this may seem, but it also shows a willingness to try, good intentions, and a hopefulness that it might work out.

Experiencing pride and pleasure in achievements

There were a few comments which showed that Elaine and Tom were aware of the progress they did manage to achieve with Jack, and the developments he made, and how pleased they were about that. When he arrived he could say only three phrases: '*shut up*', '*where ye gaun*[8]*?*' and '*whit ye daen*[9]*?*' However, by the time he left, he had been discharged from the speech therapist. He was using the toilet appropriately and could do jigsaws and watch DVDs, albeit for a short period of time. He had been having one or two seizures a month while at home, but only had one seizure in the time he was with Elaine and Tom.

Elaine told me that the consultant at the hospital remarked on the '*huge improvement*' she saw in Jack:

> Elaine*: cos that time he was quite calm and she says, I've never seen him like this before.* (Elaine's voice has gone soft and quiet here, I think she's sad).

Reflecting on the consultant's comments makes her feel sad, to realise that they had a positive effect on Jack.

Worn out

Looking back on it, they couldn't believe how they managed it:

> *when we look back now we think, how did we really manage it?*

They were both '*worn out*' at the time. Sadly, although their state of exhaustion and desperation was noticed by Scott, it was not responded to in a way that acknowledged it; instead Scott and his manager asked them if they would consider carrying on. At this point in the interview, Tom said he didn't think anything would have saved the situation:

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[8] Where are you going?

[9] What are you doing?

> *I don't think it would've lasted much longer, even if we had, you know what I mean? To be honest I don't, it was just…* (sounding quite despairing and defeated)

Letting go

Their sadness at Jack leaving was palpable. Elaine said that she didn't want to talk about it, although she did: '*it was terrible*'. They were still wondering how he was and what he was doing. They wondered if he would recognise them, while reflecting that his attachment to them was superficial – '*he would have gone with anyone*'. Elaine cried quietly and Tom said '*it was the wee man that got to us*'. They worried about him being rejected again: '*is he going to get passed from pillar to post or*…?'

4.7.3 Process of the interview

Using laughter to cope

Elaine and Tom used humour throughout the interview, perhaps as a way of tempering the severity of what they were trying to cope with. The humour may also have been a way of counteracting feelings of being undermined and humiliated by Jack's laughing at their attempts to rein him in and put down boundaries. It also made it possible to laugh off difficult feelings.

Tom said that Jack thought everything was '*hilarious*'. When I asked them what they liked about Jack, this is how they replied:

> Tom*: oh he was just a character,*
> Elaine*: he was a wee character, he was,*
> Tom*: he was fun, he loved- he loved- everything was fun to Jack, whether he was- you couldn't help but laugh,*
> Elaine*:* (laughs gently)

They repeated this later in the interview, that '*you couldn't help but laugh at him*'. Perhaps Jack's wish to turn everything into a joke was projected into them, and they found that the only way they could cope was to laugh about things. Of course, it's always easier to laugh about things after the event, and their descriptions of events were indeed amusing. I joined in with their laughter at times, for example when describing car journeys and trying to keep Jack safely strapped into a car seat, which he would continually undo. I asked if this improved over the time he was there. Tom said that it got worse, and then changed this to '*he got better at it – very experienced*' and we all laughed. There was much relief in the laughter; however, I felt that it was partly colluding with Jack in his attempts to reduce everything to a joke.

Caught up in the whirlwind

The narrative was dominated by stories of Jack running off, throwing things and lashing out. I was caught up with, and felt equally overwhelmed by, the whirlwind they described, so much so that I missed out on things I wanted to hear about. For example, Jack was not toilet trained and still in nappies when he arrived, and I asked Elaine what it had been like taking him through toilet training. Elaine replied with a comment about how uncompromising Jack could be: '*it was Jack's way or no way*', but then moved on immediately to another story about his lack of any sense of boundaries and that they had to '*zone off a bit of the back door*'. The subject of toilet training was lost. Later, Elaine told me that there had been '*one good thing*', which was Jack's sleep routine:

> Researcher*: and did he sleep at night?*
> Elaine*: aye, that was one good thing. We had a good routine at night time, he knew that, and his bath, but again, even in the bath, could only have a few inches of water, cos he would just lie flat, then he would go up and slide,*
> Tom*: he didn't want to come out the bath, loved his bath, when it was time to come out he would lie rigid like that, you had to- maybe pull the plug, let the water out,*

Again, she was unable to remain on the subject of the good sleeping routine as it got overtaken by memories of yet another difficult issue, here bathing.

4.7.4 SSW Interview

Heather had been working with a private sector fostering agency for four years. Her job involved recruiting, assessing and supervising foster carers. She had assessed Elaine and Tom four years before and continued working with them. The agency policy required that she visit her carers once every two weeks, but in this case, Heather said she visited more frequently, '*probably weekly*', '*maybe even more*'.

They did not have a great deal of information about Jack before he was placed with Elaine and Tom, nor time for planning and preparation. Heather said that they were completely taken aback by what followed:

> *We knew he was going to be- we knew he was difficult and he had some difficult behaviours, eh, but for a three-and-a-half year old child, you don't expect them to be as severe as what they were.*

In other words, nothing from Heather's experience prepared her for what Jack presented them with.

She said that he was '*the most difficult child we placed*' in that year, challenging their usual presumption that teenagers are the most difficult to place. She very quickly found that the usual strategies which she would suggest to carers did not work with Jack; she said that '*you just had to leave him*'.

Heather was there on the day Jack arrived, to support Elaine and Tom. She said, '*he was still in nappies and his speech was very very poor*' and '*we knew he had real difficulties*'. She went on to describe how aggressive and unpredictable Jack could be – '*he would just launch things*' - but also how much she liked him and that he was a loving boy:

> *Because he would just launch at you and just pull, but he was also so loving as well, and he loved a cuddle, and he would always say, 'sorry Elaine'.*

She commented on his physical size and strength, remarking that he was unusually big and strong for a three-year-old. She had been on the receiving end of Jack's assaults but noted that '*Elaine got it every day*'. I asked Heather if she had any idea at the time why Jack was like that. She replied that '*he'd had quite a horrendous background*' and that his parents had a '*chaotic lifestyle*'.

Heather used the word '*prison*' when telling me about how Elaine and Tom had to move everything in their house, '*it was like a prison to them and Jack really*'. She said that she:

> *couldn't go in with scarves or jewellery or wearing glasses, I had to take them all off and put them in the car- leave them in the car before I went in.*

Despite this, he was a child she '*loved going to see*'.

She thought that the most difficult thing for Elaine and Tom was Jack's physical aggression, but for her it was:

> *the lengthy period it was taking for the local authority to get their processes moving*

and the fact that Jack was having weekly contact, which '*was clearly having a significant impact on him*'. '*He'd be more violent, he would wet, he would soil*' and his behaviour in nursery deteriorated then too. She sounded shocked that, despite what she saw as proof that contact was unsettling and possibly even re-traumatising for Jack, it continued. Despite her anger at the social work department in relation to the weekly contact Jack had with his parents, she understood that Scott had a procedure to follow. She said that:

> *his hands were tied with a lot of things, he couldn't progress things.*

Heather spoke of the '*fantastic achievements*' Jack made at nursery, that his speech came on '*leaps and bounds*', and he was out of nappies. She was clearly pleased about this, and proud about what Elaine and Tom had managed to achieve with Jack:

> *Elaine would get on the floor with him and read his stories, because, when he first came, he couldn't sit for any length of period of time, when he left them he could sit* (voice slowing down as though to emphasise this achievement) *and watch like Fireman Sam, in front of his- on his wee seat, his wee bean bag and that and watch the TV for maybe about twenty minutes? Which was a great achievement for him.*

However, at the time, it seemed that any progress Jack made would be followed by regression:

> *You would think you were getting a wee bit- a wee chink forward, and then it would be like- and then it would just be straight back.*

At the end of the six weeks, which had been agreed as the time Jack would stay, '*nothing*' happened. Birth parents were still being assessed and rehabilitation was still being considered as an option.

In the end, it was the agency who said that the placement should end. Heather had watched Elaine and Tom become more and more drained and exhausted as the months went on, particularly Elaine:

> *Cos it was just constant, and emotionally she was just so drained,*

She spoke of the '*constant worry*' and the '*emotional stress*' Elaine was under, which she could see as Elaine was practically in tears each time she visited. She said that '*Jack was taking over their whole lives*'.

Heather knew that Elaine and Tom wanted to hold onto Jack until he went to his permanent carer:

> *But it came to the point it was actually ourselves that said, come on, enough's enough,*

She said that,

> *They weren't thinking about themselves, they wanted to think about Jack more than anything else.*

Just like Elaine and Tom, she called Jack '*a wee character*' and said that was what made it '*really difficult for them*'.

Later in the interview, she commented on how Elaine and Tom reached the point where they '*just accepted his behaviour*' and would say, '*oh, that's just Jack*'. She reflected that they had come to believe that nothing would work with Jack, so they had given up trying.

The agency had a sound debriefing policy, which was part of their routine at the end of any placement. It was attentive to carers' needs, offering them counselling if they needed it. Elaine and Tom had said that they were satisfied with the input Heather was giving them and didn't feel they required anything more. Heather and her agency thought that '*another family placement wouldn't be suitable*' for Jack, that he wouldn't manage it. '*It would tear their family apart probably*' she added. They recommended that he needed a therapeutic environment.

Reflecting on what she might have done differently, Heather said:

> *it's really really important to try and get a good match, for the child and the family.*

She would have '*dug for a bit more information*', suggesting that, had they known more about Jack and his needs, they may have placed him elsewhere. She summed up the assumptions made about looking after an under-five in the following comment:

> *We knew he was difficult* (four-second silence) *but you think, how difficult is a three-and-a-half year old going to be?*

Like Elaine and Tom, Heather felt sorry for Jack and worried about his future, '*don't know where he'll end up*'. She said that Elaine and Tom were still not over the loss of Jack, and that it was still '*quite raw*'.

4.7.5 Support

- When talking about their decision to end the placement, Tom said that '*we weren't getting any help*' and '*we were getting nothing*', echoed by Elaine, '*nothing*'. Later, when I asked them directly about the support they received, Tom said:

  > *To be perfectly honest, as far as they were concerned it was 'out of sight, out of mind'.*

- Tom said there were no phone calls and very few visits, adding that it was '*shocking*'. Elaine said that the SWs always made it for Jack's weekly contact, but did little else. This must have felt as though the social work department was giving support to Jack's parents and their relationship with him, but not to them. This was particularly hurtful when they saw how contact was affecting Jack, that he soiled himself after visits and came out in a rash.
- Good support from Heather, particularly in the first few weeks, when she visited regularly.
- Support was not mentioned as an issue by Scott.
- Heather had support from her manager.

4.7.6 Reflections

Jack, at the age of three-and-a-half, was already on his fifth placement, and had felt uncontainable to at least two sets of carers. Such a high number of changes of placement has serious implications for Jack's ability to form a secure attachment. This was a classic example of a child with disorganised attachment, whose behaviour was unpredictable, shifting between affection and aggression without warning.

In their attempts to provide some sort of containment and a feeling of safety, Elaine and Tom had to remove items which Jack might throw and create safe areas by cordoning off sections of their house and garden. It seemed impossible to think about developing Jack's internal controls, instead they had to control the environment around him. The carers were in a state of '*constant worry*', they had to be vigilant and on the alert twenty-four: seven, a state which could not be sustained and which led to them becoming exhausted and worn out.

This situation meant that they were depriving themselves of the usual household objects and ornaments, and depriving Jack of specific toys, and feeling as though they were depriving him of food, as he would have just gone on eating. This led to Elaine and Tom feeling like restrictive, denying, withholding parents, rather than the generous, giving carers they set out to be, or at a distance from the selves they were used to being and imagined themselves to be.

Jack's running off all the time, throwing things, grabbing things, hitting and kicking – something had gone seriously wrong with exploring the environment from the safety and confidence of a secure base. Jack was in an unthinking state, a mindless running away from thinking, a defence against allowing anything in. Instead, he projected everything outwards.

In reflecting on this case, I found Bion's ideas about the development of thinking, and the development of an apparatus for thinking, very helpful. The capacity for thinking is developed in connection with the capacity for tolerating frustration. Bion (1967: 112) wrote of 'the need to decide between evasion of frustration or of its modification'. When modification of frustration does not occur, the thoughts become 'fit only for evacuation' (1967: 112), just what we see happening with Jack. This unthinking state was projected into Elaine and Tom, who eventually gave up trying and lost their capacity to think about Jack. This was noted by Scott, who observed the shift from warm, nurturing carers, to the strain, burn-out and feelings of defeat he saw take place over the ten months.

The obstacles to making clear decisions about Jack's long-term future led to a state of drift, and Jack remained with Elaine and Tom without any discussion or planning. This process of drift was mirrored in the way that Elaine and Tom drifted into feelings of defeat and despair, and the way in which their optimism and good intentions were lost. Elaine and Tom had strengths and resilience, but these were not developed or strengthened by support and encouragement.

A regular space to reflect on what was happening was absent. The carers were left on their own without that kind of support, so their strengths and positive aspects were quickly crushed by the extreme demands of the task.

As in all of the other cases, there was an overall sense of a lack of progress and development, despite evidence to the contrary. Although Jack did make progress, and Elaine, Tom and Heather gave good examples of this, the impression was of not getting anywhere, of things continuing to be too hard, too exhausting.

5 DISCUSSION

5.1 Introduction

This chapter reflects on the emotional experience of the placement, and the emotional impact on each of the carers. All of the carers described a significant emotional impact on themselves in their task of providing care for the children. This was often not acknowledged until after the child had gone, when carers realised with hindsight just how difficult it had been and how much they had soldiered on, attempting to deny the extent of the impact on them.

SSWs saw the emotional impact on their carers: in case 1, the carer was described as '*traumatised*'; case 2, she was '*stressed*', '*tired*' and '*worn out*'; case 3, the '*emotional drain*' she saw in the carer because of the child's '*clinginess*'; case 4, the SSW referred to the carer '*feeling that she just didn't know what to do*'; case 5, '*if they can't do it, I'm really worried about this*'; case 6, '*emotionally she was just so drained*'.

Hindle (2001) noted the usefulness of a psychoanalytic perspective which encompasses the concepts of transference, countertransference, anxieties and defences, in understanding the children's states of mind and the impact on workers and carers. I will now discuss my findings from a psychoanalytic perspective, particularly in relation to anxiety and the way in which it became apparent in the placements. Anxiety is considered by psychoanalytic thinkers to be 'inescapable' and 'part of the human condition' (Woodhouse and Pengelly, 1991: 10/11). A central point for this study is the impact on carers' emotional life of the anxiety inherent in the placements, and the defences mustered against it.

As well as the impact on carers' internal emotional world, there was an impact on carers' wider world affecting personal relationships with partners and family members, and with professionals in the network. The all-consuming nature of the task left little or no time for any other areas of the carers' lives. This was exemplified by comments made by Carer 3: '*I can't breathe*' and '*I mean you're not the person that you used to be*'.

I begin with a look at some of the external factors which had a bearing on the placement, and then go on to describe the emotional impact on carers, and on the system around them.

5.2 External Factors

There were a number of external factors in each case (see Figure 1). Carers had to contend with a majority of these factors in addition to the 24-hour care of the child. These factors had an impact on the carer-child relationship, affecting the carers' practical and emotional availability to the child, as well as affecting their thoughts and feelings about the child.

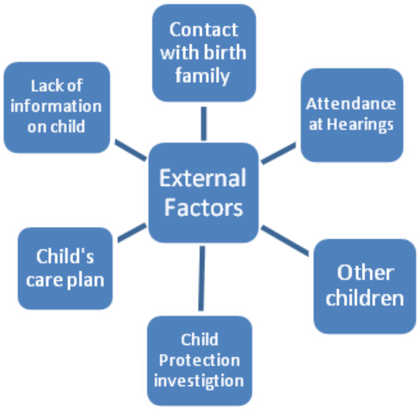

Figure 1

Lack of information about the child was a feature in all six cases. Those carers who had the child for a longer period of time (5 and 6) received some information as time passed; however, in all cases, the child arrived with only the most basic information. Carers were vague about reasons for the child being accommodated and had few or no details about their development or family history. It is possible that more information had been given to carers at the time and subsequently forgotten; however, all the carers said that they would have liked more information. In some cases, (1, 2 and 4) there was an absence of any precise information provided at the start of the placement. See **Table 3** and note that information 'known' appears only three times.

The importance of information sharing is cited by Taylor et al (2008), and that carers should be included in all planning and decision-making processes. Hill-Tout et al (2003) noted that foster carers reported that social services and health guidelines about confidentiality meant that they were denied information about behaviours and management strategies that could be useful to them.

	Child's early history	Developmental history	Why child in care	Information from home or previous placement
Case 1	Vague	Not known	Vague	Very little
Case 2	Not known	Not known	Known	Vague
Case 3	Not known	Not known	Vague	Vague
Case 4	Not known	Not known	Some information	Very little
Case 5	Some knowledge	Not known	Known	Some information
Case 6	Some knowledge	Not known	Known	Very little

Table 3

In cases 1 and 2 there was an on-going child protection investigation when the child arrived. This had significant implications for how the carers thought about the birth family and previous carers. The effects of suspected abuse being visible on the child's body had an immediate impact on both carers. The child's experience did not have to be imagined or guessed at as he had so obviously been on the receiving end of physical abuse. The presence of an on-going investigation added stress to the placement and created an atmosphere of suspicion and fear.

A child's care plan is central to the aim of providing the security of a predictable future for a child. In all six cases, at least initially, there was a degree of uncertainty or vagueness for the foster carers about a) precise reasons why the child had been accommodated and b) plans for the child's future.

In two of the cases (1 and 5) the SW had a clear care plan and a decision had been made that the child would not return home. However, in Case 5 there was an unresolved dispute about whether or not the child should be placed with her sibling. In case 2, although there was a clear reason for the child being accommodated (*'unexplained injuries'*), there was doubt and uncertainty about who had caused the injuries.

Birth parents were a reality of the children's lives, past and present, and all of the children, at least initially, had contact with their birth parents. In three cases (2, 5 and 6) this involved an additional responsibility for the carer to take the child to and from contact, causing much disruption and giving less time for the many other daily tasks involved in looking after a child. Kenrick (2009: 17) noted that for these children, the routine is of being 'frequently on the move' between carers and birth parents. In only one case (5) did the carer say that the child 'loved' her contact. In all other cases it had been a stressful experience for the child, often leading to unsettledness and an increase in symptoms such as enuresis, crying, attempting to over-eat and oppositionality.

Birth parents played a surprisingly minor role in the three narratives (carers, SWs and SSWs). In light of the children's distress and experience of neglect by birth parents one might have expected to find strong feelings of anger towards them; however, this was not commonly the case in the interviews.

Although birth parents were mentioned in all six cases, it was identified as a theme in the data in only one case (3 – 'violent mum'). Carers 1 made no comment about the parents' failure to protect and care for their child. In case 2, thoughts about birth parents were included under 'Living with conflicting feelings' as the carer and SW noted how perplexing it was that they liked the parents, saw them as '*nice*' and '*good parents'*, yet they were under suspicion of having physically harmed their child or failing to protect him from physical harm. Carer 4 expressed anger about what the child had been exposed to, but this was stated quietly. The two cases where the child remained in placement for longer periods of time (5 and 6) were the two cases where anger towards birth parents was more openly stated. In 5, the SSW made clear links between the child's behaviour and the birth parents as did the carer, albeit more tentatively; in 6, too, the carers were more open in expressing the view that birth parents had seriously failed their child.

Carers often have to attend Children's Hearings, to provide information on how the child is doing in placement. This is a formal meeting about the child, potentially adding stress to the carer who might be faced with the child's birth parents. In Case 2, this was noted as an additional stressor as the carer had to attend Hearings, with the child, every three weeks.

Other children featured as an important finding. Five of the six carers had other children in placement, birth as well as foster children. These children took up space both physically and emotionally and, in some cases, were firmly established in carers' minds before the index child arrived. Five of the six carers cited the effects on other children as one of the reasons for ending the placement.

In Case 4, the carer was faced with a dilemma, where she wanted to protect the other children from the index child's sexual behaviour but did not want to give up on the child, who she felt she could have worked with had there been no other children in placement.

Carers 1 and 3 were still in the throes of processing the experience of looking after children who had already left the placement. When Carer 3 reflected that the timing of the placement was '*all wrong'*, she mentioned the two under-fives she'd had just prior to the index child. Now, she was able to acknowledge just how disturbed all three children were, and how worn out she was by looking after them, one after the other. Although they were not physically present, these two children were still in the carer's mind when the index child arrived and perhaps the experience with them influenced how the carer started out with the 'new' child. It seemed that there was nowhere for the impact of loss to be considered (see later section on Loss).

5.3 Emotional Impact

I begin this section with comments on the impact of trauma and loss on the placements.

Trauma

Hyper-vigilance and hyper-arousal, common features of trauma, were reported by all six carers in relation to being unable to let down one's guard for a moment. Carers were constantly on the alert, waiting for something to happen. Carers 1 said: '*you just never knew the minute*'; Carer 2 said: '*you are constantly, your ears are up like this, in case you've heard him*'; Carer 3 found herself behaving like a hyper-vigilant child when out in the local area with the child, as she feared meeting the child's birth mother; Carer 4's family were '*on edge'*, wondering if the child was going to start masturbating again; Carers 5 had to watch the child constantly for fear of her aggression towards her sister; and Carers 6 said: '*you had to watch him, couldn't take your eyes off him*'. The Literature Review referred to the 'arousal continuum' (Perry, 2006) and increased levels of cortisol linked to experiences of trauma.

Another experience common to trauma is the feeling of not being in control, or helplessness (Freud, 1926). Carers 1 described feelings of terror and hysteria, in the other foster child and in the foster mother, who also spoke of feelings of '*panic*'; carer 2 was unable to do the usual, ordinary chores and activities; carer 3 screamed back at the child; carer 4 became increasingly anxious about not being able to control the child's sexual touching and not being able to shield the other children from this. In some cases, this led to having to take control, or attempting to over-control, as in case 5 where the carer spoke about it being like a military operation, and case 6 where the carers had to control the environment. None of the children in the sample were able to regulate stress, not having had the experience of their distressing communications being held, thought about and returned in a more manageable form (Bion, 1962), in the earliest stages of their lives.

The ability to realistically appraise any progress made by the child was lost, as it was over-shadowed by the extent of the difficulties the carer was faced with. This is reminiscent of the reactions of a traumatised individual who has lost the capacity to realistically appraise the potential threat within a situation. There was a gradual wearing down of energy and enthusiasm until carers felt worn out and exhausted. In some cases (1 and 3) this happened much more rapidly than in others.

Secondary Trauma

Cairns (2008) wrote of secondary traumatic stress in relation to adoptive parents. This phenomenon was seen in the foster carers in this sample, in their attempts to care for children who had experienced the trauma of separation from birth family as well as the cumulative trauma of neglect and abuse.

In all six cases, the children projected their fear and terror in an attempt to avoid experiencing it. Without an understanding of secondary trauma, carers were more vulnerable to experiencing the fear and terror being projected by the children. Foster carers who live closely with traumatised children are the professional group most vulnerable to secondary traumatic stress and more likely to be destabilised by the process (Cairns, 2008: 95).

The impact of working closely with distressing and potentially traumatising material was experienced by the researcher (see Section 7.7) who, like the carers, was at risk of withdrawing from or not using the support available. As Cairns (2008: 95) noted, ‘as people become disordered they withdraw from support, so that effective support needs to be alert and proactive’. It was due to the existence of a supervisory space for the researcher that this was able to be noted and reflected upon.

Loss

Loss is a significant issue for any child who is looked after away from home. However, although feelings of sadness and loss, guilt and disappointment, and compassion for the child emerged from all six interviews, the idea of loss was not a theme which emerged from the data as noteworthy. This raises a question about why the issue of loss is not being consciously thought about.

The idea of loss was openly raised in Case 1, where both the SW and the SSW wondered about the carers' level of emotional commitment to the child. Both related this to the loss of two previous foster children and how the female carer in particular was still mourning this loss. The child, too, had lost two previous carers and his siblings. Thus the shadow of earlier placements fell upon the current placement.

The other case where loss was considered significant was Case 5, where the child and the carers had experienced the loss (to adoption) of another foster child.

There was nowhere for these feelings to be thought about and processed, and both carers and children were largely left to carry feelings of loss alone, or to put them aside and ignore them. There was a recognition that carers grieve when children they have looked after are adopted or move to permanent foster care. However, in practice, there was no time period allowed for carers to process the experience. Like the children they looked after, they were expected to move on and start anew.

It may be essential to take account of previous losses, and to consider the interaction between the carers' and the child's previous losses and separations.

Anticipated loss

This is an idea which emerged from the data, and which has a significant bearing on the forming of a new relationship (see Goldstein, Freud and Solnit, 1973). Only two of the six carers believed the child would be staying with them on a long-term basis; the others expected the child to move on at some point in the near future. It was a particularly difficult experience for Carers 2, as they expected the child to leave their care every time they attended a Hearing.

5.4 Paranoid-schizoid functioning

The themes in this section have been brought together under the concept of paranoid-schizoid functioning (see **Figure 2**). The term 'paranoid-schizoid' was introduced by Klein in 1946 and refers to a state of mind where defences against persecutory anxieties

- particularly splitting and projective identification - and lack of integration dominate. The 'depressive position' (Klein, 1935) refers to a state of mind where some resolution of the conflict between love and hate has been reached, and both good and bad aspects of the caregiver can be held and thought about simultaneously. Concern for the other comes to the fore and the child is said to have developed empathy. These are not fixed positions which, once attained, remain in place, rather there is movement back and forth between the two. Particularly at times of transition or additional stress, or the re-activation of trauma symptoms, there is likely to be regression to a paranoid-schizoid mode of operating. In the cases here, the stress and anxiety aroused by the carers' experiences could be said to have propelled them into a paranoid-schizoid state of mind.

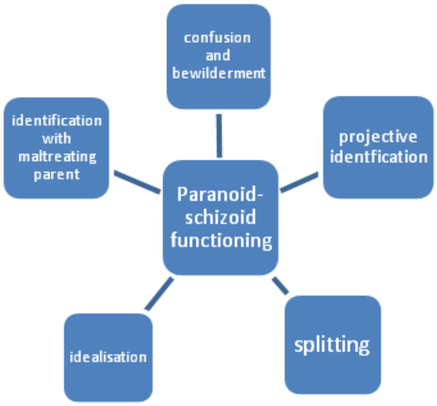

Figure 2

Splitting

An important finding of the research is how the child came to embody opposing characteristics which were difficult to reconcile. Feelings of both love and hate were aroused in the carers and they struggled to reconcile the good and bad, loved and hated, aspects of a child, just in the way that an infant struggles to integrate good and bad aspects of self and other. This is a feature of paranoid-schizoid functioning; the more realistic picture associated with the depressive position, of both good and bad being contained within one person, has not been attained (Klein, 1946).

In all cases, the carers spoke about the ambivalent feelings they had towards the child (e.g. Case 2 – 'Living with conflicting feelings' and Case 4 – 'Incongruity/paradox). There was a clear division or split between a beautiful and at times delightful child and a child with a fierce temper, full of rage, or one who cried or screamed. Carers had to grapple with the close proximity of opposing states of mind and views, such as adorable/detestable, attractive/repellent, and affectionate/violent. In case 4, I called this 'incongruity/paradox' to draw attention to the mismatch or discordance between descriptions of one child. This is a central idea, common to all six cases, as each carer spoke about the child having angelic qualities as well as monstrous qualities. In practice, this meant that descriptions of the most distressing behaviour in the child were often followed by expressions of the attractiveness of the child, or of her positive personal qualities. Carer 3: '*lovely, beautiful wee girl'* closely followed by: '*a wee bit screamy'* and '*a wee bit violent'. Carer* 4: '*she would hurt herself, she could hurt somebody else, she was gorgeous*'.

Case 5 provides an example of how feeling states were polarised: from delight to shock; excitement to terror; love (for the foster child) to hatred and intolerance (of her sister); the child's relationship with her sister and with the other foster child, the one '*horrible*' and the other an ordinary, '*happy*' relationship. It can also be seen in comments like that made by the carer when she spoke of the child's *'lovely wee angelic face*' while describing her slyly hitting her grandchild in the back of the car. In Case 6, the carers described the child as '*a wee soul*' and repeated this a further four times. This '*wee soul*' view was then not heard of again, and does not sit comfortably with the whirlwind or tornado child described.

This is a tense position for carers, which affects their view of a child and how they relate to them. Such conflicting feelings lead to confusion and muddle, and relate to projections from the child of confused and confusing emotional states.

One way of thinking about this is that these conflicting views of the child represent different unconscious aspects that cannot be held in mind simultaneously. Somehow, it was not possible to bring both parts of the child together in a meaningful way, as though integration of the two ideas was too disturbing.

It also brings to mind the concept of disorganised attachment, where the child's attachment behaviour remains unresolved (Hesse and Main, 2000). Williams (1997: 126) suggested that parents who are '*frightened* or *frightening* or both…are those who *project anxiety instead of containing it*'. Fonagy (2001: 88) wrote that, 'it is likely that children exposed to such deprivation are repeatedly confronted with intolerable levels of confusing and hostile caregiving, and are forced to internalise aspects of their caregiver that they are incapable of integrating. Their self-structure is thus formed around a fragmented and flawed image that they are forced to externalise in order to retain any measure of coherence.'

Idealisation

The dictionary definition of 'idealisation' includes 'fantasy', 'nostalgia' and 'naivety'. The retrospective nature of the study made it more likely that carers would feel nostalgic and create a kind of fantasy around their experience. However, idealisation is often a sign of splitting, when the object is split into the two extremes of ideally good or profoundly bad. Carers easily fell into expressing idealised views of the children or of how they could be helped.

Many of the carers expressed an 'if only': carers 1, 'if only he'd had a nursery placement', carer 2, 'if only I could have done controlled crying'; carer 3, 'if only she had come at a different time'; carer 4, 'if only I had had her on my own, without other children in the placement'. In case 5, there was a fantasy around the idea that the two siblings would be fine when living together. The social worker clung to the idea that these girls should live together, saying 'if only they had been placed together from the start it would have worked'. Carers 6, despite their optimism that they could keep the child longer, that they would '*give it a try*', were the only ones who openly stated that they didn't think anything would have changed the outcome, even if they had been provided with respite.

Idealisation is closely linked with disappointment, as carers fell from an idealised view that love would be enough. The carers could see the child's desperate wish to be loved and held onto a view that providing love would be a straightforward act which would solve everything. This was expressed by Carers 1 – '*a lovely wee boy, and just wanted love. He really did*' – and Carer 3 – '*lacking a bit of love, I think that was all she really needed*'.

Projective identification

In the literature review, I referred to projective identification, used as a defence against anxiety and a fear of annihilation (Klein, 1946), as a primitive means of communication (Bion, 1962), and accompanied by splitting, denial and idealisation (Joseph, 1987).

In the six cases here, the children had originally been on the receiving end of the projections of their birth parents, whether witnessing or being a direct recipient of violence and aggression, or experiencing neglect, abandonment and physical, emotional and possibly sexual abuse. In the placements, these experiences were replayed, with feelings mirrored between the child and the carer. This was most clearly seen in the cases where screaming was a major feature of the child's communication, which was a majority of cases (1, 3, 4 and 5). In case 2, the child cried and did not sleep, and in case 6, the child was constantly on the go and putting himself at risk, variations on the theme of screaming, it could be said. This led to carers feeling engulfed by the child's distress, being the recipient of the raw, unprocessed nature of the distress, and pushed into experiencing the child's state of mind, a clear example of projective identification and of the child getting 'under the skin' of the carer (Ironside, 2004: 39). The result was that carers had to expel the child in order to get rid of an unprocessable experience for themselves, mirroring the process of the child expelling undigested feelings into the carers.

In case 3, the carer found herself either giving in to the child or being overwhelmed by feelings, as though her only choice was between giving in to her or being engulfed by intolerable feelings. By giving in, she avoided the intolerable feelings; however, it was also a kind of 'giving up'. On the contrary, by identifying with the child and how she felt, the child's rage got right inside the carer. This led to a situation where neither carer nor child felt they could understand or were understood. The carer was knocked off-balance by the whole experience of trying to provide care for this child and there was a temporary inability to process and return projections in a tolerable form (Bion, 1962).

The fear for the carer was that she would be seen as a 'wilfully misunderstanding object' (Bion, 1967:117). None of the children appeared to have had an experience of a maternal object who could make sense of their world. Not having internalised the idea of a containing object left the child ill-equipped to use the containment and understanding which was being offered. This was experienced as intolerable for carers, whose aim was to provide containment and understanding.

Confusion and bewilderment

A common finding was that of not being able to understand a child or his behaviour. This was captured by the word '*unfathomable*' in case 1, and '*it's weird to understand*' in case 4. When carers couldn't understand the child's behaviour or emotional state they lost confidence in their skills and in their natural, intuitive parenting abilities – their ability to successfully tune in to a child. Every carer described reaching a point where they no longer knew what to do. This led to feelings of self-doubt, being removed from one's comfort zone, and feeling lost from oneself, an indication that the impact of projective identification is being experienced.

Identification with maltreating parent

In every case, there was a loss of the carers' previously held positive identity as a successful or effective foster carer. Smith et al (2009) noted that identity has been found to be a central concern in many IPA studies. Parenting strategies which were successful with other children did not work with these children. The positive feelings with which carers started out were over-shadowed by feelings of hopelessness, defeat, despair and not knowing what to do next. Carer 2 admitted having reached the point where the thought of giving up fostering came into her mind.

Carers were pushed by the child's emotional communication into the position of feeling like the depriving or maltreating parent. In case 3, the carer found this position so intolerable that she ended up giving in to the child and, at one point, screaming back at her, directly acting out that identification. It was particularly apparent in Case 6 where the carers had to apply so many restrictions and felt that they were constantly saying 'no' to the child. The feeling of constantly thwarting the child's wishes was in direct opposition to the carers' motivation to give care, love and attention to the child. This is reminiscent of the child described by Henry in 'Doubly deprived' (1974: 39), who went to great lengths to accuse her of neglecting him.

5.5 Avoidance of Emotional Impact

In all six cases there were examples of carers avoiding the emotional impact on them of looking after the children (see Figure 3). This was related not only to avoiding forming a close relationship with a child who they knew would stay with them only for a short time (carers 1, 2, 4 and 6) but also to the emotional impact of the distressing behaviour of the children. The extent of the children's disturbance was such that carers had to somehow evade the full impact of their emotional communications in order to survive. From a psychoanalytic perspective, this would be seen as defences against anxiety.

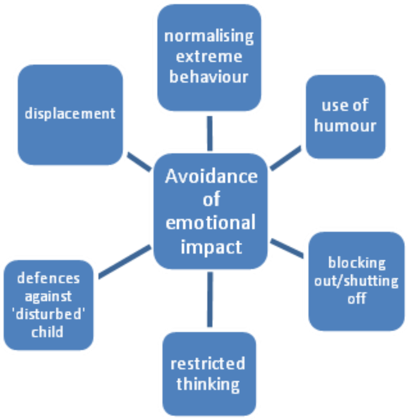

Figure 3

The idea of normalising extreme behaviour was present in cases 3, 4, 5 and 6, but was particularly striking in 5 and 6. Carers 5 spoke about how they just got used to the child screaming and that it had become '*normal*', only realising after she had gone how much they had done this. In case 6, there was a process of giving up and an acceptance that this was just how the child was and nothing they did could alter it.

Cases 1 and 5 gave examples of restricted thinking, or thinking that was circumscribed by the need to feel one is in control and coping. Case 1:

> *this is bedtime and it's time to sleep. Good night and I will see you in the morning. No more noise.*

and Case 5 where the carers had to co-ordinate their movements so that the child was never left on her own with her sister – '*it was like a military thing*'. Taking this position does not encourage reflection on the meaning of the child's behaviour.

Carers 5 learned to block out or shut off from the child's screaming. Again, this does not encourage reflection on the meaning of the behaviour and creates an emotional distance between child and caregiver.

Carers 6 were the only ones to use humour so obviously as an antidote to the pain aroused by their contact with such an emotionally challenging child.

Displacement of emotional impact by talking about the impact on another child rather than on themselves was also present (strongly in 1 and 4, but also present in 2, 3 and 5). There was a process of putting aside one's own thoughts and feelings about the emotional impact of the situation, due to concern about other children. Carers 1 and 4 were more comfortable talking about how the other children in placement experienced the child than talking directly about how it made them feel. This allowed carers to talk about the powerful feelings raised without having to think about them in relation to themselves.

Describing the impact on another child shifts it away from being about the carer and something they cannot tolerate, a defence against experiencing the full impact of trying to provide care for these children.

Defences against the ‘disturbed’ child

All of the SWs were at pains to identify a stable and long-term placement for the child. However, SWs 3, 4 and 5 were at such pains to secure a long-term stable placement for the child that the child’s disturbance was side-lined for fear that this might negatively influence the long-term outcome for the child. This avoidance of seeing the disturbance in the child has a positive motivation to the SW who doesn’t want to jeopardise the long-term outcome for the child by labelling him as ‘disturbed’. Seeing the whole child, or bringing all aspects of the child together, would facilitate the process of thinking about what the child’s disturbance means. However, there seemed to be no way of talking about disturbance, or a shared idea that a space for thinking and reflecting would be beneficial.

In case 3, although the carer made a link between the child’s behaviour and her mother’s behaviour, she minimised the effects of the child’s behaviour on her and her family, not wanting to label the child as ‘disturbed’. In this way, she didn’t have to ‘blame’ the child for the breakdown, instead blaming herself and her circumstances. Both the carer and the SW knew of specific events in the child’s life which might lead to trauma and saw evidence of neglect, but neither of them made the link to the child’s current functioning in a way that would help to make sense of the situation. While the SSW mentioned the background of the child as being important, she blamed herself for the breakdown. Everyone looked for reasons and excuses elsewhere than the child’s early experiences. The carer and SSW blamed themselves and the SW blamed the system. Each avoided acknowledging or recognising the role of the child herself – her early life experiences and the influence of her background.

SW5 put aside her own observations of the child’s disturbance to adhere to what she saw as the best plan for the child i.e. securing an adoptive or permanent placement.
There seemed to be a lack of imaginative thinking about the child’s presenting problem having meaning. Only a minority of participants (one-third) made an explicit link between the child’s presentation and their early experiences. Information about the

child's early experiences was not used in a way that might have helped those involved to understand the child.

This is a defence against looking too closely at what the child himself brings to the situation, and what it means to think about the neglect and trauma of his early life, which no-one has been able to prevent, 'an unconscious response to the pain of facing what has really happened to them, and a defence against recognizing the degree of damage' (Youell, 2002: 124). Thus we see how the abuse, neglect and trauma work their way through the system, arousing feelings of guilt, anger, the need to blame, and even distorted thinking, as other reasons are sought to explain the phenomenon, to avoid facing the reality of the child's early experiences.

Unfortunately, these ways of responding to the emotional impact of the experience, while allowing carers to feel that they are coping in the moment, do not encourage an attitude of wondering about the child, and tend to lead to a sense of being stuck. If the carer is unable to process the experience, then she is not able to help the child work through his experience.

5.6 Emotional Availability and Reverie

Bion (1962) introduced the concept of 'reverie' to describe how a mother expresses her love for her infant. Essentially, reverie describes the caregiver holding the infant in mind and providing love and understanding, a key component of containment. It is necessary for the caregiver to enter this state of mind so as to be 'capable of reception of the infant's projective identifications' (Bion, 1962:36). If these projective identifications are not received and understood, the infant increases the intensity of his projections, and a cycle of not feeling held or understood is activated, while if they are held and thought about, and returned in a more benign form, 'alpha-function' (1962: 7) is in operation.

Feelings of being lost from oneself, feeling out of control, impotence, despair and hopelessness, and secondary trauma, are important in relation to a carer's emotional availability, and to what might be thought of as failures in containment. The idea of a foster carer being in, or being prepared to cultivate, a state of reverie is an important one to have emerged from this research. Just as a mother needs practical and emotional support to be in a state of reverie, so do carers need support in their task of providing nurturing care to the children.

The emotional impact of looking after the children had a bearing on the carers' emotional availability. In case 1 the carers were still grieving the loss of two previous children and they had made a special connection with another foster child who had arrived before the index child; in case 2 there were four other children and the carer getting no sleep; in case 3 the carers were worn out by two previous periods of respite with particularly disturbed children; in case 4 the carer had gone over numbers and was then faced with behaviour which was particularly emotionally challenging; in case 5 the carers had many previous foster children, many children currently around, the loss of a foster child, and an exhausting situation with the index child; in case 6, the carers became worn out by the demands of a hyperactive and risk-taking child. The situation was one where there was either a gradual erosion of emotional commitment, or starting out with less emotional availability due to earlier losses. In the Literature Review, I drew attention to the importance of the emotional availability of caregivers in alleviating the effects of traumatic experience.

There are two aspects to emotional availability which should be considered. The first is when a carer's emotional availability is diminished due to a previous experience, before the foster child arrives, and the second is when it is diminished due to the current situation, brought about by the challenges of looking after the child. Carers 1 and 3 fell into the first category, Carers 1 grieving the loss of two previous children who had been adopted, and Carers 3 exhausted and emotionally drained from the experience of providing respite care to two children described as particularly disturbed. All of the carers in this study fell into the second category.

It may be essential to consider carers' increased vulnerability when both these aspects are present, and to consider what would serve to enhance a carer's emotional availability.

Sternberg (2005:82) includes the following in a list of skills she would expect a psychotherapist to possess: 'open oneself to the experience of shock'; 'tolerate anxiety and uncertainty'; 'waiting for meaning to emerge'; 'realistic hopefulness'; and 'retain apparently contradictory experiences simultaneously'. All of these are skills we expect carers to possess, or states of mind we hope they can bear. All of these points were experienced in varying degrees by the carers in my sample. However, carers do not have the training and experience of a child psychotherapist. To Sternberg's list, with carers in mind, I would add: support, capacity to withstand projections, awareness of transference and countertransference, and a regular space for reflecting.

This leads to a question about how much a carer is expected to function as a mother/therapist – someone who has the capacity, as Rosenfeld (1987:160) describes it, 'to enter into an intense relationship and to retain his function of putting experiences into words'. This function is crucial in cases of child abuse and neglect, where there are clear failures in early containment. There is also a question here about the language used in the UK, where we tend to refer to foster 'carers' rather than foster 'parents', as they do in the US, while hoping carers can have the qualities of parents.

5.7 Process of the Interviews

The use of defences against distress and anxiety could also be seen in the way in which carers told their story. In all 18 interviews, I paid attention not only to what was being said but also to *how* it was being said. The 'how' of the interview was the emotional expression of the traumatic impact of the placement. This was more obvious in some cases than others, for example in the interviews of Carers 1 and 4, and SSW 4, the process of the interview was identified in the data analysis as a significant theme.

Figure 4

It is important to take into account the fact that the subject under discussion was the breakdown of a placement and that one of the purposes of the study was to hear about the disturbing aspects of the carers' relationship with the child. Carers were being invited to talk about an experience which had been upsetting and distressing, and had ended with a decision that the child had to leave their home, a decision not made lightly by any of the carers.

Communication of distressing material

As expected, the communication of disturbing and potentially distressing material, with the potential for traumatisation of the speaker and the listener, was a significant feature of the process. All of the carers had been through a difficult process therefore their accounts awakened feelings in them which were uncomfortable and upsetting. Feelings of despair and hopelessness were just below the surface and, understandably, carers were reluctant to recall them. The difficulty of staying with an account of distressed and distressing behaviour, by changing the subject or drifting off mid-sentence was present in all cases. There was a reluctance to stay with disturbing thoughts. Ogden wrote that 'it requires two minds to think a person's most disturbing thoughts' (Ogden, 2009: 91).

These carers had no one with whom to share and reflect upon this state of mind; like the child, they were left to struggle with it alone.

The difficulty in finding words to express the experience was a particular feature of Case 1 where the carers turned away from frightening thoughts, as though part of the experience was ‘beyond words’. The child’s screaming led to the carers feeling frightened, bewildered, overwhelmed, and that the child was beyond their help or understanding. Silences and unfinished sentences gave indications of feelings which were painful to access and to express. The child’s inability to articulate in words what he was feeling so affected the carers that they struggled to articulate their experience to me. Confronting or thinking about the child’s terror was frightening so they cut off from it and were defended against thinking about it.

In Case 4, there was a need to talk about the disturbing material, but this was accompanied by what I have termed ‘grammatical distancing’, with the carer moving from first to second person.

The carers in Case 6 used humour and a light-hearted approach as a counter to the severity of the child’s behaviour. This indicates how difficult it was to understand and make sense of the child’s emotional state, and respond to it in a way that felt helpful to both them and the child. What happened instead was that they felt defeated and gave up trying. This was reflected in the way my questions got lost and I didn’t get to hear about ordinary tasks like toilet training and sleep routine; ordinary parenting tasks and thereby skills fell by the wayside, there was no room for them.

Interviewee Anxiety

The level of anxiety about being interviewed varied. Only 7 out of all 18 showed some degree of anxiety therefore it was not as significant an issue as I had expected it might be. However, it became clear after the interview that SSWs 2 and 4, and carer 4 had been more anxious than I had realised. Only carer 1 expressed anxiety before the start of the interview. All participants, including those who showed overt anxiety, appreciated the opportunity to talk about the experience, underlining the therapeutic function of the research interview.

Silences and over-flowing accounts

The presence or absence of silences was an important factor in the participants' accounts, and whether there was an outpouring of words (2, 3, 4 and 6), as in the recounting of a trauma, or an awkwardness (as in 1 and 5). It is notable that carers 1 and 5 were going through a grieving process. These two were the shortest interviews in terms of length and word count, suggesting that there was some kind of block or resistance to a free-flowing account of the experience.

A Space for Thinking

There was a secondary gain to the research project, which was that the interviews provided a space for thinking and processing of the experience. By inviting the participants to talk, listening to their story and sharing the experience, they felt the process had been helpful. Two carers and one SSW thanked me directly, and subsequent informal feedback from SWs and SSWs indicated that carers had found it helpful.

Researcher Countertransference

There were two areas in which I made use of the concept of countertransference. The first was during the interviews, at the times when I unwittingly got caught up in the re-telling of the story of the placement. This happened in case 4 when I expressed my shock along with the carer, when the child took a boy's hand to touch her ('*oh my goodness*') and again in case 5 when I put into words too soon and too strongly what I felt the carer's experience must have been like ('*it must have driven you up the wall*'). At such moments, I lost the neutral stance of the researcher and found myself experiencing with the carer the shock and dismay which they had originally experienced. In case 1, the shortest of all the interviews, I, too, got caught up with the difficulty in finding words to express the experience, with a temporary loss of interviewing technique and ability to draw out of the carers more details about their experience. In case 6, I found myself joining the carers in their humour about a situation which was tragic for both them and the child.

The second area in which I had a strong countertransference experience was after the interviews, during the phase of typing up the transcripts and, following that, the Data Analysis. In all six cases, during the typing up of the transcripts phase, I experienced feelings similar to those of the carers. These were powerful feelings of sadness about the children's life journey so far, but also a feeling of helplessness, as though I could do nothing about it. Listening closely to the voice recordings, in order to type them verbatim, brought me closer to the sorrow and bewilderment of the carers, who still felt hurt and disappointed by the fact that they'd had to end the placement prematurely. I experienced a strong wish that the children had been brought to my attention earlier – as a Child Psychotherapist – so that I could have provided intervention to them and their carers, echoing carers' wishes that they had got the children earlier, before the damaging experiences.

I later reflected in my supervision that during this phase I had felt alone with these thoughts and feelings, as though no-one could help me with them, just as the carers had felt at the time of the placement. The theme of being unable to, or feeling that it was not possible to, access help was repeated. This links with the idea of support, and whether or not it was able to be used. I was thus afforded a glimpse of not only how the carers felt but also the children. The child's diminished capacity to use what was on offer from the carer was transferred to the carer, who doesn't use the support which might be available, and thence to the researcher.

5.8 System Issues

There were several issues which emerged as significant in the network or system around the child and the carer (see Figure 5) and which had an important bearing on the caregiving relationship. They could be thought of as the emotional impact on the system, and defences against anxiety in the system. Woodhouse and Pengelly (1991: 226) wrote of the emotional elements of working within an institution; they also found in their research that inter-agency relations were 'imbued with defensive behaviour' (1991: 181).

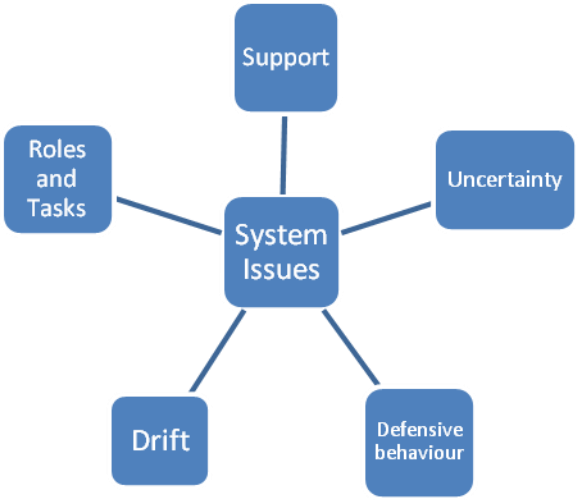

Figure 5

Support

There was no expectation in the system that support of an emotional nature is necessary and should be provided automatically for everyone involved with children who have experienced neglect and abuse as well as rejection and trauma. Providing support is a key task for carers, SWs and SSWs, but each of them was thwarted in their attempts to provide it. This led to feelings of self-doubt, as well as ineffectiveness, and had a significant impact on their sense of professional identity.

Carers had an ambivalent stance towards support, in that they saw the need for it and wanted to have it, but did not like to ask for it for fear of being seen as not coping. Carer 2 spoke about being encouraged by her husband to phone her SSW, and wanting to do this, but not doing it '*because this is my job*'. There was a need to be seen as coping, and the idea that asking for help may be interpreted as a weakness. All of the carers had an attitude of 'you just have to get on with it'.

Carers did not have an established expectation that support of an emotional nature was available. Although carers knew they had a SSW, and that person was there to support them, there was no clear idea of what that support could look like, other than asking for practical support, e.g. respite or a nursery placement for the child. However, even this was difficult for some carers to ask for as they saw respite as disruptive to the child and, for themselves, a risk of being seen as not being able to cope or failing in some way (particularly Carers 2 and 5). Carer 2: '*I'd been a foster carer for two-and-a-half years and I've never asked for respite, never*'; and Carer 5: '*I didn't want to put her in respite but we had to start doing it'*.

Carers 1 and 2 experienced a change in their SSW, 1 a month or two before the arrival of the child and 2 during the placement. Carers 1 seemed to have little expectation of support and rarely mentioned their SSW, in fact struggled to remember her name. Carer 2 was clear about the negative impact on the placement of lack of support, and she felt unheard and misunderstood. The SSW who took over the case also felt unheard and misunderstood, by both her agency and the carers. Although Carers 3 and 4 felt supported by their SSWs, the SSWs themselves did not feel that they had provided the support they wanted to, or which they realised was required. SSW3 felt her support did not get through to the carers. She related this to the carers' lack of confidence in their own abilities and lack of time to provide more substantial input. SSW4 felt she did not have enough knowledge of sexual behaviour in under-fives to provide meaningful support; she could provide only support of a practical kind, i.e. '*write everything down'*.

The two SSWs who were more able to provide support, which included a space to think about the child's distress and challenging behaviour, were the two who had a longstanding relationship with their carers and, in Case 6, the private fostering agency, more time to give to carers (at least fortnightly visits as opposed to monthly).

In most cases, the carers felt left with the child, with little contact with the child's SW. In case 1 the SW was rarely seen; case 2 the SW changed mid-way; SW3 was angry with the fostering agency and with the carers; SW4 was involved only to take the child to contact with birth family; SW5 was involved in a dispute with the fostering agency regarding the siblings being placed together; and SW6, in the words of the carer, it was a case of '*out of sight out of mind'*. SW6, however, felt that his visits added stress to the placement as the child became over-excited and hyperactive when he visited. This is an important point, that the child's support person felt his presence increased the child's tendency to become unsettled and over-active, rather than providing the intended support. This is a good example of the kind of situation which might lead to a child and SW failing to develop a positive relationship because no-one helps the SW to think about the child's distress and the meaning of his behaviour.

Support for SWs and SSWs

Despite the wealth of skills and experience of the workers in this sample, several of them acknowledged a gap in their experience or training in relation to specific issues with which the children presented. This was true in Case 4, where the SSW said she had no experience of sexualised behaviour in under-fives and would welcome training in this area; it was true also in Case 1 where the SSW had twenty-five years of experience of working with children, but lacked specific experience with very young children, and acknowledged having no idea where the child's screaming came from: '*no understanding of why he started screaming*'.

SWs were affected on an emotional level as they had to cope with the distress of moving very young children from home or between placements. This was particularly true for SW3, who articulated the pain involved in moving children from placement to placement:

> *it's very stressful because you have to move, you have to look these children in the eye and move them.*

SW1 also commented on this:

> *what have we done to this poor kid, he'll just go with anybody*?

Similarly to carers, the workers were aware of the importance of and need for support for themselves, but there was a kind of acceptance that it would not be regularly or reliably provided. One SSW actually stated, once the DVR was switched off, that she did not receive regular supervision. Like the carers, direct anger about this was rarely expressed, this being clearly expressed by only three participants, and hinted at by two. Munro (2011: 91), in her *Review of Child Protection*, notes the effects on SWs of child protection work: 'emotional exhaustion, depersonalisation (or cynicism), and reduced personal accomplishment', highlighting the necessity for regular support of a high quality.

Roles and Tasks

The main social work task is the care and protection of children. Individual needs of the child and promotion of development are equally important aspects of the social work task; however, until care and protection are in place these will inevitably be less of a priority. At times, the SW cannot avoid being caught up in the issue of securing permanency and finding a suitable placement for the child, or investigating a Child Protection concern, or following a social work principle, for example that siblings should remain together wherever possible.

In practice, as we have seen in the Cases here, the SW had to concentrate on finding a placement, or attending Hearings to have contact with birth parents reduced, rather than spending time with the individual child in a way which would allow a relationship to form and understanding to follow. I would suggest that this is a dilemma for SWs which strikes at the heart of personal and professional motivation for being a SW, leading to feelings of frustration, disappointment, dissatisfaction and despair.

It is perhaps inevitable that the priorities and concerns of carers and SWs will be different. However, if each cannot hear the other the child will be the one to suffer, and tension and disagreement will arise between the SW and the carer, or her representative, the SSW. I had an experience of this dilemma in the interview with SW3, when I felt there was a conflict between the researcher/interviewee agenda. The SW was caught up in her anger towards the system while I wanted to hear about the relationship between the child and her carers. I experienced in brief what the carers must have felt, not just in this case, when the SW was unable to hear her concerns. It was simply not possible to hear about the child when the system issues loomed so large.

This finding is significant enough to warrant further research into professional roles and personal motivation for choosing a particular job/role, and what happens when one's role conflicts with the demands of the situation or the institution.

Uncertainty

Being in a state of uncertainty was a common theme in all six cases. Carers frequently expressed anxiety about the child's future, and frustration about the lack of clarity and lack of progress in forward planning. The presence of uncertainty and doubt is fertile ground for the growth of anxiety, affecting both carer and child. Burck and Cooper (2007: 193) wrote that 'in times of uncertainty…we are less than receptive to others' view and are most at risk of polarising our differences and taking up oppositional positions'. Munro (2011: 38) noted that uncertainty 'pervades the work of child protection', and, later, that 'a key responsibility of leaders is to manage the anxiety that the work generates' (2011: 107).

There was uncertainty not only about the child's past but about the child's long-term future, as well as about the child's current needs. There was also uncertainty around whether or not the child would be rehabilitated to the birth family. In cases 1, 5 and 6, where a decision had been made that the child would not be returning home, confusion arose from the fact that the child was still having regular contact with birth parents. Uncertainty for foster parents regarding whether a child would stay with them or return to birth parents was a key finding in research by Kenrick (2010).

Defensive behaviour

Defensive behaviour could be seen in the tendency towards anger and blame, and the conflict which arose in a majority of cases. Anger and blame are defensive reactions against anxiety, highlighting a need to find 'a receptacle to carry the anxiety' (Woodhouse and Pengelly, 1991: 232).

Conflict

In the same way that splitting occurs as an intra-psychic process between two people, it can also occur within groups and organisations, or systems:

> splitting can be seen to occur within families, groups, agencies, professional networks or society in general, wherever there is an unconscious need or desire to keep 'good' and 'bad' aspects of the same person, situation or experience separate and far apart because integration of them is felt to be profoundly painful, discomforting and disturbing. (Hindle and Shulman, 2008: 8)

In the examples here, splitting arose within the system in the form of two opposing views, leading to open disagreement. There was an acknowledged conflict or disagreement between the Social Work and Fostering Agencies in four of the six cases (2, 3, 4, and 5). Interestingly, in these cases, there was a more supportive relationship between SSWs and carers. When carers and SSWs came together in their view of the child they created a stronger defensive stance against the SW view.

In Case 2, there was one group considering a return to the birth family and another saying that this could not happen. As long as the abuse to the child continued to be denied there could be no resolution to the situation or possibility of birth parents getting the help they needed. In Case 3, the SW felt that the carers were not committed to looking after an under-five.

In case 4 there was a difference of opinion about the child's behaviour, having a clear impact on how understood and listened to the carer felt. The absence of support of the carer's view of the child created a tension in the relationship between the carer and the child's SW; they viewed each other suspiciously, with an absence of trust. In Case 5, the split in the system was represented by one view that the two siblings could live together and another view that it was impossible for them to live together. The difficulty lay in acknowledging the part played by the unprocessed destruction and hatred aroused by early neglect and abuse.

While considering the main carer and SW concerns, I realised that they were not the same (see Table 4). The table points out the difference between carers focusing on the children and SWs on planning and external factors. This highlights the way in which differences of opinion and disagreements arise, leading to antagonism between the SWs and carers, with carers not feeling listened to or supported, and SWs feeling frustrated and angry at having to move their child. This is a good example of how conflicts about planning can arise, noted by Cooper and Webb (1999) as a key theme in their research.

Child	**Main Concerns (Carer)**	**Main Concerns (SW)**
Alistair (1)	Screaming; fear of the bath; fussiness with food; worried about risk to other child.	3rd placement breaking down; consequences of moving child again; indiscriminate friendliness; concerns about carers' preference for another child.
Mohammed (2)	Child not sleeping.	Injury to child; delay in care planning until resolution of Child Protection concerns.
Gemma (3)	Screaming; clinging to carer.	Anger at having to move child again; the assessment by placement services; questioning carers' capacity to look after child effectively.
Jess (4)	Masturbation; aggression to self and others.	Disagreeing with carer's interpretation of child's behaviour; questioning carer's capacity to look after child effectively.
Chelsea (5)	Screaming; aggression; troubled sibling relationship.	To have child and her sister adopted together.
Jack (6)	Hyperactivity; risky behaviour; lack of containment.	To secure permanency for child and reduce contact with birth parents; concerns about child's presentation and complex developmental needs.

Table 4

There was a difficulty in thinking clearly *together* about a child. There appeared to be no forum, or arbiter, to help the two parties to reconcile their opposing views. Woodhouse and Pengelly (1991: 180) suggest that such an 'irreconcilable conflict of ambivalent feelings' was 'the prime source of internal pressure generating the aggravated anxiety and defensive reactions to it'.

Anger

Anger was expressed in relation to having to move a child again (SWs 1, 3 and 4) and fearing that more harm was being done than good; a perceived lack of commitment to the child (SWs 1, 3 and 4); the different views about placing the two siblings together (5); and feeling neither listened to nor supported (1, 2, 4, 5 and 6).

Alongside anger came guilt and blame. Feelings of guilt were connected to the need to blame someone, as seen in cases 3, 5 and 6 when the SW blamed the placing agency for the poor outcome. Some SWs (2 and 4) blamed their own agency for not getting it right. SWs felt guilty about being part of a system which moved children around frequently (particularly 1, 3, 5) while SSWs blamed themselves for wrongly placing a child (1, 3, 4 and 6).

In all cases, there was little openly expressed anger towards birth parents. This was true for carers, SWs and SSWs. It was raised in only three of the cases (2, 5 and 6) and even then only in a gentle, muted way. The anger was expressed elsewhere, displaced in the system, as if there were a taboo against expressing anger about birth parents, and the anger was now about the potential abuse by the care system.

The existence of feelings of anger and outrage about what has happened to a child need to be acknowledged and allowed to be expressed and thought about in a safe and supportive way, as do feelings of hatred and anger which can be aroused by close involvement with the children and 'their tangled, ambivalent and conflicted caring systems' (Cooper and Webb, 1999: 120).

Drift

An absence of clear planning and decision-making led to drift in the system, akin to the 'professional inertia' described by Britton (1981). This is exemplified by the phrase, '*in limbo'*, used by SW2 to describe the situation until the Child Protection issue could be resolved, and in Case 6, where the child remained for ten months rather than the originally planned six weeks.

The presence of uncertainty, conflict and anger created a situation where drift more readily took hold. The process of 'drifting off', which was seen in the system, was mirrored in the interviews. Just as carers could not finish a sentence, and the experience seemed 'beyond words', so in the system things were left to drift. Emanuel writes of a 'collapse of strategy' when workers become 'disoriented' and 'confused' about the passage of time (Emanuel: 2002:175), a projection of disorganised attachment.

5.9 Need for a reflective space

This final section points to the need for a space for thinking and reflecting for carers, and across the system. The findings of this study have shown how carers found themselves repeatedly experiencing negative emotions, projections of the children's intolerable pain and distress, and how this was also experienced in the system. In such circumstances, a space for reflection becomes essential.

The study has discovered a tendency towards the avoidance of pain and distress by focusing on role and task, rather than thinking about the meaning of a child's behaviour, but also how pain and distress interferes with successful performance of role and task.

The need for a reflective space has already been noted by several psychoanalytic writers: to think therapeutically about the meaning of a child's communications (Emanuel, 2002: 170) and to contain the 'destructive forces that may abound within the fostering experience' (Ironside, 2004: 48). Miller (2002: 58) has pointed out that it is far more challenging to reflect when feeling irritated, angry or anxious, when 'one's sense of competence can be threatened by such children'; this signals how much more important it is to provide a space for reflection.

The idea of providing containment has already been discussed, in relation to providing love and understanding to the infant, and to promote the child's capacity to think and reflect for himself. The notion of a receptive container is just as important for the system, to contain the distress evoked by working with the children. A space for reflecting, and the provision of containment for carers and workers, would increase the capacity for reverie and emotional availability, as well as increasing awareness of the emotional impact of this work.

An idea which has emerged from this research is the notion of a flexible container. Carers were often expected to be the kind of container which can expand and make room for more, not only literally in taking in children, but also symbolically in taking in the projections of the children and the expectations of the system. Three SSWs spoke about having to push their carers' boundaries or 'stretch' them, in a desperate attempt to keep the placement going. They reflected on the importance of knowing carers well in order to gauge whether or not they could be stretched. This was also an issue for the SSWs, who had heavy workloads and themselves felt stretched to provide the required support. Similarly, the SWs of the children had to 'contain' a heavy emotional load both in relation to the children's life stories and in moving them from home to placement and from placement to placement.

The lack of a space for thinking and reflecting resulted in decisions being taken quickly, for example in the sudden moves of children between placements. SWs often expressed surprise at the suddenness with which carers requested a placement to end. The system made sudden moves and also experienced them, without having time to think about them. This mirrors the experience of the child who is moved from home suddenly, or from one placement to another. All of the children experienced sudden moves from their family of origin; the children in cases 1, 3 and 6 experienced further sudden moves between placements. Decisions made suddenly suggest an absence of thinking or time for discussion, or the presence of acting out something which has not been worked through.

In the absence of a system which understands and makes use of psychoanalytic concepts (containment, splitting, projection, defences against anxiety) the problematic use of unconscious processes will continue and increase, eventually overwhelming the system and leading, as we have seen here, to breakdown. As Moylan (1994) has pointed out, as the distress of the client group increases, so does the likelihood that unconscious communications will predominate. Becoming aware of unconscious communications, or the likelihood that they are occurring, leads to a reduction in their potency. Joseph (1978:108) summed up this process with the following words, in her case taking place between patient and analyst, but which apply readily to the process taking place between carer and child: 'The more the patient is using primarily primitive mechanisms and defences against anxiety, the more the analyst is likely to feel that he is being involved and used by the patient unconsciously, and the more the analysis is a scene for action rather than understanding'.

Bentovim (1992) wrote of 'trauma-organised systems' and, more recently, Wakelyn (2011: 304) wrote of 'virtuous' and 'vicious' circles of interactions, the former promoting 'developmental organisation', the latter 'trauma-driven organisation'. In the absence of a reflective space or an understanding of projection and projective identification, the system is at risk of providing an experience of 'anti-containment', or what Williams (1997: 126) calls 'omega function', where the object is 'both impervious and overflowing with projections'.

Just as Fonagy (1991) noted the importance of Parental Reflective Functioning, to hold the child's mental states in mind, so the system requires a space for reflecting to promote this capacity in carers and workers. This might promote a shift to depressive position functioning and a progression towards development and integration.

Countertransference

This is a key psychoanalytic concept whereby the therapist understands something of a child's experience via the feelings aroused in her. In its broadest sense, countertransference refers also to the feelings which belong to the therapist, from her own life experiences, but, here, I am interested in the sense in which something of what the child feels is experienced by the therapist: 'the state of mind in which other people's feelings are experienced as one's own' (Halton, 1994:16).

While countertransference is experienced directly within a therapeutic relationship, it can be useful to be aware of how it operates in other situations, such as the one described here between child and carer. There are examples in all six cases of carers experiencing something which originated in the child. For example, in Case 1, 'beyond words', is an example of how the carers experienced an aspect of the child's inner world, which he was unable to communicate in words; in Case 3, the carer described being so filled up with the child's screaming that she didn't know what to do; and Case 4, where the carer experienced the child's despair and hopelessness of ever being understood and feeling held: '*I tried and done everything*'.

Countertransference involves a valuing of subjective experience and, as such, is at odds with the scientific tradition of objectivity. However, within qualitative research, there has been a move towards the valuing of subjective experience, for example Hollway and Jefferson's 'psychosocial subject' (2000) and Smith's IPA (2009), and there is a long tradition within psychotherapy of using countertransference as a working tool (e.g. Winnicott, 1947, Heimann, 1950, and Salzberger-Wittenberg, 1970).

An understanding of countertransference would play an important part in developing the kind of reflective space I am trying to describe. It allows one to be more aware not only that feelings are being stirred up, but that they may not necessarily originate in oneself. Like Reflective Functioning (Fonagy, 1991) it helps to open up a space which allows observation of and reflection on a situation, without being drawn so far into it that it overwhelms us. As Hollway (2012: 26) noted, 'retaining the capacity to think in circumstances that may lend themselves to just the opposite'.

5.10 Aftermath

All six carers had been through a harrowing experience. Although SWs and SSWs are trained and, to some extent, prepared for such an experience, they too experienced the situation as distressing and were affected by it. The SWs and SSWs were now far more likely to seek support and training. SW3 made it clear that she now stands up to the fostering agencies and expects much more information, so that she can make an informed choice about the ‘fit’ of her child with the carer. All the workers would be more careful about which child is placed where.

Although none of the carers in this sample chose to give up fostering, they were more likely to decide not to look after children of a particular age again. This has implications for fostering agencies and recruitment, as well as the carers’ personal and professional identity.

Despite their experience, carers 5 openly stated that they were not discouraged by the experience. However, they would ask for help for a child more urgently when they felt it was required. Carers 6, too, despite being deeply affected by the experience, were not discouraged and were still fostering. Carers 1, 2 and 3, however, had made the decision not to take another child of a similar age. Carers 1, encouraged by their SSW, decided that their strength lay in caring for babies; carers 2 and 3 stated that they would not take another child of a similar age. SSW4 would be more assertive in future about overloading the carer, who had gone ‘over numbers’ to take the child.

The process of the research interview, and the opportunity it afforded for reflecting on the experience, led to participants feeling that they could ask for something for themselves, e.g. support and training. The interview allowed them to articulate what previously could not be thought about, and to gain confidence once the researcher had shown she could hear, take in and think about the experience.

5.11 Risk and protection in placement breakdown

Table 5 is an example of the risk factors which emerged from this study as being significant to the placements, and suggested protective factors.

RISK FACTORS	PROTECTIVE FACTORS
Too many external factors e.g. CP investigation, attendance at Hearings. Unacknowledged loss. Presence of other children. Presence of confusion and uncertainty. Frequency of contact with birth parents. Lack of support for carer with emotional impact of the experience; and lack of practical support. Conflicting views about child. Anger and blaming in the system. Drift. Absence of a space for thinking.	Clear care plan. Sharing of information. Time and space to acknowledge and process loss. Awareness of emotional impact of living closely with children who have experienced abuse, neglect and/or trauma. Emotional availability of foster parents. Capacity to emotionally receive child (reverie). Good support systems. Awareness of psychoanalytic concepts. A space for thinking and reflecting.

Table 5

6. CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

The aim of this study has been to look closely at the relationship between a carer and a child, where the distress and disturbance of the child became so unbearable for the carer that the placement had to be ended. The study asked whether psychoanalytic thinking could be useful in bringing understanding to this situation.

Six carers, who had been through the experience of ending a placement with an under-five, were interviewed, as well as their SSW and the child's SW. The data produced by the interviews was subjected to an in-depth analysis using IPA.

The findings have highlighted the importance not only of paying close attention to external factors, but to the profound effect on participants of the emotional impact of the experience, including examples of secondary trauma, loss, and questions of personal and professional identity. The findings have thrown light on the complex interplay between a distressed and disturbed child, the unassuming goodwill and intentions of carers, the failure of support systems to reach their intended target, and preoccupation with policy matters (e.g. CP issues, keeping siblings together).

The financial cost to society if appropriate support and intervention are not provided at an early stage, as well as the personal cost to individuals, is potentially huge. If a child continues in a pattern of breakdown, leading to residential care, involvement in the criminal justice system and, beyond, to repetition of the pattern with their own children, then the intergenerational transmission of neglect, abuse and trauma continues.

The study has shown the significance of unconscious processes in a situation involving close contact with a child with early experiences of abuse, neglect and trauma. Several psychoanalytic concepts were used to throw light on the responses of individuals and the system around those individuals, responses which, at the time, were largely reactions to the child’s distress and led to acting rather than thinking and reflecting. A reluctance to make links with the child’s early experiences and how they continue to affect not only the child but the entire system, and the absence of a space for thinking and reflecting, points to the need for development of reflective practice.

The findings add substantially to our understanding of defences against recognising and understanding anxiety, distress, disturbance and loss, and the reverberations of this throughout the system. The suggestion is that an understanding of psychoanalytic concepts, or consultation with professionals trained in this way of thinking and working, and the use of reflective practice, will increase awareness of the impact of involvement with children like those described in the study, and the ways in which carers can be affected.

The study has allowed deeper insight into why, despite existing knowledge, breakdown of placements continue to occur, and has offered a means of thinking about such situations. Knowing about factors which increase the risk of placement breakdown is not enough without a way of thinking about and understanding them. The study has highlighted the need to be aware of these points, to be prepared for their emergence, and to provide training and increased understanding of the processes described.

6.2 Reflections on Methodology

I chose a fairly broad theme as the subject of investigation: placement breakdown and the caregiving relationship under stress. A more narrowly defined focus might have allowed for greater concentration on a narrower range of topics. However, the study has shown that investigating the caregiving relationship raises many and varied complex issues, within and beyond the specific relationship between carer and child.

Doing only one interview does not allow the depth and range which a therapeutic relationship would, or even a series of therapeutic interviews, and does not lead to the same evidence or conviction. Furthermore, the nature of the subject, which involved the communication of disturbing and distressing material, takes time to process and requires a level of trust in the interviewer. Carers started out feeling wary, guarded, defensive, because something had gone wrong and they may have feared being criticised. However, the study has shown that one therapeutic interview proved to be useful to carers, SWs and SSWs, in terms of processing a painful and disturbing experience. The therapeutic function of one interview provided a space for thinking and reflecting on the experience so that something useful was achieved even with only one interview.

The retrospective nature of the study meant that I did not hear about the relationship as it happened. The carers' accounts may have been quite different had I interviewed them while they were in the thick of it, rather than later when they had had time to put some distance between themselves and the situation. The study has provided an insight into how it might be to work with carers and children while they are going through the experience, and an insight into the kinds of issues which are likely to arise, and the interactions which might take place.

I had expected that using IPA would be likely to generate an abundance of themes and ideas but I was not prepared for how much rich data would emerge from each interview. This meant that I have had to be more selective with the material. Had I concentrated on two interviews (six in all, including the SW and SSW) I would have been able to provide a much more detailed and in-depth presentation of each carer's and child's experience. Having concentrated on six cases (eighteen interviews in all) I have had to condense the material and select only those themes which were more evident. Although this has meant excluding some material from individual cases, using six interviews allowed me to strike a balance between single case study and a wider study, drawing out common themes and comparing across cases, whilst still being able to provide a detailed picture of child, carer and placement.

Using IPA formalised a process which was not unfamiliar to me, as a Child Psychotherapist, as a means of analysing and interpreting a large quantity of data. It is a useful means of organising thoughts and ideas, and grouping them systematically into themes, all of which can be traced back to the original transcripts.

Something I discovered about using IPA was the emphasis on language. During the analysis stage, interaction with the text, rather than another human being, was the activity. This led to a deeper interest in the participants' use of words and manner of telling their story, and was a different activity than being with the participant. A methodology with a primary focus on language, e.g. Narrative Analysis or Discourse Analysis, may have allowed for deeper exploration of the use of language, particularly in a study using interviews as the main method of data collection. However, this interest in the participants' use of language could be seen as a process similar to that which I have referred to as 'avoidance of emotional impact', where by focusing on the use of language I could perhaps avoid fully experiencing the emotional experience of the carer and the child. However, my grounding in Child Psychotherapy and use of the countertransference helped me to keep my focus on the emotional experience of the participants.

6.3 Recommendations

The recommendations are divided into three sections: practice, policy and research.

6.3.1 Practice

Preparation, on a practical and an emotional level, is a key factor for carers taking on the task of caring for a child with early experiences of abuse and neglect. Carers should be prepared for the emotional impact of looking after the children, for the capacity to tolerate feelings of uncertainty and doubt, and for the likelihood of being in a position of knowing very little about a child. Furthermore, they could be prepared to expect feelings of disappointment, despair, defeat and failure, and for looking after a child who presents with different 'faces', leading to conflicting views and feelings in those involved.

Carers and professionals should be given the opportunity to develop the use of reflective practice. This would provide a space to talk about disturbance and what it means, and an understanding of how the early experiences of the children, of abuse, neglect and trauma, are reflected and re-experienced in the system. This would include a space for thinking about anxiety and distress, for individual carers, SWs, and SSWs, and at an organisational level. This is particularly required while the child is in placement, and might help to prevent the placement becoming 'a scene for action rather than understanding' (Joseph, 1989). It could also be useful once the child has left the placement. The attainment of psychoanalytic observation skills would be helpful here: 'to find in oneself an internal space to observe, to tolerate uncertainty, confusion and anxiety about what is observed, and to think in a reflective way that may lead to increased understanding' (Miller, 2002:59).

Reflective practice should include attention to how the experience of loss can impede a child's and a carer's capacity to form new relationships. Feelings of loss are likely to exert a powerful influence in the system, while not necessarily being obviously the case. This would afford carers and professionals the time to think about reluctance to confront the impact of feelings of loss, and how feelings of loss are defended against.

The notion of emotional availability should be thought about, and attention paid to whether a carer is more vulnerable than usual due to a recent loss or other distressing experience.

The presence of other children in a placement can be a positive factor in some placements and can promote a child's fitting in. However, in most of the cases here, the presence of other children led to conflicting demands on carers and it felt, at times, impossible to meet the needs of both (or all) children. It may be important to pay attention when carers talk about how the disturbance of one child impacts upon other children in the placement. This may be an indication of how much the carer herself feels disturbed by the child, but projects these feelings onto other children as it may be easier to do this than to talk directly about oneself. The other aspect of 'other children' which it may be important to pay attention to is the other children who might still be in the carers' minds, competing for space, or perhaps unmourned.

The impact of birth parents on both the child's and the carers' internal world is a factor which should be taken into account, with an awareness that powerful feelings about birth parents, which may remain largely unconscious, might play a significant part in how a carer feels towards a child.

In these cases, there was an increased likelihood of conflict. This relates to the relationship between the individual carer and child as well as to the dynamics which occur at a systems level. The opportunity to resolve conflicting feelings, or the ability to tolerate their co-existence, should be encouraged, rather than open disagreement and stalemate.

There was an increased likelihood of feelings of anger in all areas of the system, and the need to blame. Feelings of anger and blame need to be acknowledged without such feelings being directed towards specific individuals.

6.3.2 Policy

There is a need for regular, reliable support which is informed and knowledgeable i.e. support with expertise. An increased awareness of the obstacles to seeking support and using it effectively might help to eliminate the problem of support not reaching its intended target. Support should be on-going rather than episodic. This is required for carers, SWs and SSWs.

The importance of training for everyone involved needs to be highlighted. This could include training, and/or consultation with professionals with specific expertise e.g. Child Psychotherapists, clinicians from the specialist LAAC team, or Organisational Consultants, and could include increased familiarity with the following concepts, to promote understanding of individual children and of complex situations: trauma; secondary trauma; disorganised attachment; anxiety and defences against anxiety; projection; splitting; transference and countertransference; reverie; containment.

Cases should be approached individually, rather than applying principles across the board e.g. that siblings should stay together.

6.3.3 Research

The following five areas are proposed as ideas for further research:

The idea of support, and why support systems are not functioning as intended.

The importance of a carer's emotional availability. Is there a way of predicting or assessing which carers have less space in mind, or less emotional availability, and would therefore be more vulnerable to the challenges of looking after these children?

The role of birth parents in the lives of both the children and the carers. How do experiences of and thoughts about birth parents get translated into the internal lives of the carers and the children, and what impact does this have on their relationship? Is criticism of birth parents similar to unconscious criticism of one's own parents, or oneself as a parent? Such research would allow access to the deeper feelings towards birth parents of anger, aversion and pity, which could not be easily accessed in one interview.

The idea of loss and the avoidance of the impact of loss was an important finding. Future research could look at the role of loss in foster placements and the effects of loss on both carers and children.

Issues of identity for both carers and social workers was another key finding. It would be interesting to examine the impact on identity, for both carers and social workers, of providing care and protection for these children.

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www.scotland.gov.uk ‘The Early Years Framework’, ‘A Pathway of Care for Vulnerable Families’ and ‘Getting it right for every child in kinship and foster care’.

www.scra.gov.uk For information on the Children’s Hearings System.

APPENDIX ONE

NHS
Greater Glasgow and Clyde

Specialist Children's Services
Looked After & Accommodated Teams

Templeton on the Green
62 Templeton Street
Glasgow G40 1DA

Tel. No.: 0141 277 7400
Fax No.: 0141 277 7650

Placement breakdown in foster care with children under-five: A psychoanalytic view of the caregiving relationship under stress.

Information Sheet for Carers

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Please ask me if there is anything that is not clear or if you would like more information.

Who is conducting the research?

The research is being carried out by Gillian Sloan Donachy, Child Psychotherapist from the Looked After and Accommodated Children's Mental Health Team, a specialist CAMHS service within NHS Greater Glasgow and Clyde.

What is the purpose of the study?

I am doing a Clinical Doctorate at the Scottish Institute of Human Relations in conjunction with the Tavistock & Portman NHS Foundation Trust in London, which is a national centre for the training of child and adolescent mental health professionals and also a major provider of mental health services. As part of that course, linked to the University of East London (UEL), I am now writing a research thesis on the experience of placement breakdown with under-fives.

I want to research what can be learned from the experiences of foster carers who have had a child in placement, aged under-five, who has experienced early abuse and neglect, which they had to bring to an end before this had been planned. I realise that this is a potentially sensitive area for discussion. My aim is to learn something about what a child brings to a placement that makes it seem impossible to go on caring for that child, and about what happens to a carer's attempts to provide care.

Why have I been invited?
You have been invited to take part because you have had the experience of placement breakdown with an under-five.

Do I have to take part?
It is up to you to decide. I will describe the study and go through this information sheet, which I will then give to you. You will be asked to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This will make no difference to your caregiving role or to any support or training you may receive in the future.

What does taking part involve?
It involves an interview, lasting between sixty and ninety minutes, and consisting of a series of open-ended questions to allow you to talk freely about your experience. I plan to record the interview using a digital voice recorder, but will only do this with your permission.

What happens to the information?
Your identity and personal information, and that of the child, will be completely confidential and known only to the researcher. The information obtained will remain confidential and stored within a locked filing cabinet. The data are held in accordance with the Data Protection Act, which means that I keep it safely and cannot reveal it to other people without your permission. Any disclosures made during the interview, not already known to the fostering agency and the social work department, will be shared with them. The voice recording will be transcribed by me into a text document and the text will be used in the final thesis. If you do agree to take part, I will change names and other details so that no-one will be able to recognise the child or your family. The completed thesis will be lodged in the Tavistock library, as would any subsequent publication based on it. Should you wish, I will provide you with a summary of the outcomes of the research.

What are the possible benefits of taking part?
The results of the research will be shared with other professionals so that they can use what has been learned to help other children and carers in the future. Doing research like this is an important way of developing and improving our understanding about the help we can offer children and young people with the difficulties they and their carers encounter. I hope that the understanding gained from this research will lead to the development of an intervention with carers and children which will allow them to remain together without the need to face the final resort of placement breakdown.

Who has reviewed the study?
This study has been reviewed by the NHS Greater Glasgow and Clyde Local Research Ethics Committee, and by the Doctoral Research Team of the Tavistock/UEL.

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Dr Andrew Dawson (Independent Contact)
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60 Kinfauns Drive
Glasgow
G15 7TS
Tel: 0141 207 7100

If you have a complaint about any aspect of the study:
If you are unhappy about any aspect of the study and wish to make a complaint, please contact the researcher in the first instance but the usual NHS complaint mechanism is also available to you.

Thank you for your time and cooperation

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Placement breakdown in foster care with children under-five: A psychoanalytic view of the caregiving relationship under stress

Information Sheet (for social workers)

I would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Please ask me if there is anything that is not clear or if you would like more information.

Who is conducting the research?

The research is being carried out by Gillian Sloan Donachy, Child Psychotherapist from the Looked After and Accommodated Children's Mental Health Team, a specialist CAMHS service within NHS Greater Glasgow and Clyde.

What is the purpose of the study?

I am doing a Clinical Doctorate at the Scottish Institute of Human Relations in conjunction with the Tavistock & Portman NHS Foundation Trust in London, which is a national centre for the training of child and adolescent mental health professionals and also a major provider of mental health services. As part of that course, linked to the University of East London (UEL), I am now writing a research thesis on the experience of placement disruption with under-fives.

I want to research what can be learned from the experiences of foster carers who have had a child in placement, aged under-five, who has experienced early abuse and neglect, which they had to bring to an end before this had been planned. I realise that this is a potentially sensitive area for discussion. My aim is to learn something about what a child brings to a placement that makes it seem impossible to go on caring for that child, and about what happens to a carer's attempts to provide care.

Why have I been invited?

You have been invited to take part because you were the social worker of the child at the time of the placement disruption.

Do I have to take part?

It is up to you to decide. I will describe the study and go through this information sheet, which I will then give to you. You will be asked to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason.

What does taking part involve?

It involves an interview, of approximately one hour's duration, consisting of a series of open-ended questions to allow you to talk freely about your memory of the placement disruption. I plan to record the interview using a digital voice recorder, but will only do this with your permission.

What happens to the information?

Your identity and personal information, and that of the child, will be completely confidential and known only to the researcher. The information obtained will remain confidential and stored within a locked filing cabinet. The data are held in accordance with the Data Protection Act, which means that I keep it safely and cannot reveal it to other people without your permission. Any disclosures made during the interview, not already known to the fostering agency and the social work department, will be shared with them. The voice recording will be transcribed by me into a text document and the text will be used in the final thesis, including quotes. If you do agree to take part, I will change names and other details so that no-one will be able to recognise the child or you. The completed thesis will be lodged in the Tavistock library, as would any subsequent publication based on it. Should you wish, I will provide you with a summary of the outcomes of the research.

What are the possible benefits of taking part?

The results of the research will be shared with other professionals so that they can use what has been learned to help other children and carers in the future. Doing research like this is an important way of developing and improving our understanding about the help we can offer children and young people with the difficulties they and their carers encounter. I hope that the understanding gained from this research will lead to the development of an intervention with carers and children which will allow them to remain together without the need to face the final resort of placement breakdown.

Who has reviewed the study?

This study has been reviewed by the NHS Greater Glasgow and Clyde Local Research Ethics Committee, and by the Doctoral Research Team of the Tavistock/UEL.

Contacts:

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London
NW3 5BA

Dr Andrew Dawson (Independent Contact)
The West Centre
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Glasgow
G15 7TS
Tel: 0141 207 7100

If you have a complaint about any aspect of the study:
If you are unhappy about any aspect of the study and wish to make a complaint, please contact the researcher in the first instance but the usual NHS complaint mechanism is also available to you.

Thank you for your time and cooperation

APPENDIX TWO

Specialist Children's Services
Looked After & Accommodated Teams
Templeton on the Green
62 Templeton Street
Glasgow
G40 1DA
Tel No: 0141 277 7400

Subject number: 001

Placement breakdown in foster care with children under-five: A psychoanalytic view of the caregiving relationship under stress.

Consent Form for Carers

Please initial the BOX

I confirm that I have read and understand the information sheet dated 07/02/11 (version 3) for the above study and have had the opportunity to ask questions. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights or my role as a foster carer being affected. ☐

I understand that any new information I may disclose of a child protection nature will be shared with the relevant agencies. ☐

I understand that information may be obtained from the child's social worker and from my linkworker, and I agree to this. ☐

I agree to the interview being recorded on a digital voice recorder. ☐

I agree to take part in the above study. ☐

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Name of Participant	Date	Signature

Specialist Children's Services
Looked After & Accommodated Teams
Templeton on the Green
62 Templeton Street
Glasgow
G40 1DA

Tel No: 0141 277 7400

Placement breakdown in foster care with children under-five: A psychoanalytic view of the caregiving relationship under stress.

Consent Form for Social Workers

Please initial the BOX

I confirm that I have read and understand the information sheet dated 14/02/11 (version 1) for the above study and have had the opportunity to ask questions. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

I understand that any information I may disclose of a child protection nature will be shared with the relevant agencies. ☐

I agree to the interview being recorded on a digital voice recorder and quotes used in the final thesis. ☐

I agree to take part in the above study. ☐

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Name of Participant	Date	Signature

APPENDIX THREE

INTERVIEW SCHEDULE (carers)

Introduction: Thank you for agreeing to be interviewed as part of my research project. I expect this interview to last for approximately an hour, but it may take longer. I won't let the interview run for longer than 90 minutes, if that's ok with you. As already agreed, I'm going to voice record the interview, which I will switch on now. (Speak date and time into the dvr.)

Lead-in questions:-

How long have you been a foster carer for?

Why did you decide to become a foster carer?

Was (child in question) the first child you fostered? If not, how many children had you fostered before this?

What was the composition of your household at the time of (child in question) placement?

What was the reason for (child in question) being accommodated (as you understand it)?

What information were you given about (child in question) prior to placement?

Was this the right amount of information? (Prompt: would you like to have had more or less?)

Ok, can you tell me about what happened when (child in question) was placed with you?

What were your first impressions of (child in question)? (Prompt: what was your immediate response on meeting him/her? Prompt: how would you describe child in question's personality?)

Did these first impressions change? How?

How would you describe your relationship with (child in question)?

What did you like about (child in question)?

At the time, what were your main concerns about (child in question)?
Did anyone listen to your concerns?

At the time, did you have any ideas about why (child in question) was like this?

(Prompt: if details have not already emerged, ask now in more detail about specific behaviour of (child in question).)

Which of these behaviours you're telling me about did you find most challenging?
And which behaviours did you personally find most distressing?

How did this behaviour make you feel? (Explore this in as much depth as possible)

What was the emotional atmosphere like in your home?
How did child's presence affect other family members and life at home?

What did you do at the time?

What support did you have? Did anyone offer help or advice?
Can you think of any help or support which would have been helpful to you at the time?

Did you feel that you were able to fulfil your role in caring, nurturing and being a good parent-figure?
Did your perception of yourself as a carer change during this time?

Looking back on it now, do you think you would have done anything differently?

End interview: thank the participant for their time.

INTERVIEW SCHEDULE (for SSWs)

Introduction: Thank you for agreeing to be interviewed as part of my research project. As I wrote in the information sheet, the aim of the research is to understand something about the process of placement disruption or breakdown, particularly when this happens unexpectedly and with very young children. I hope to understand something of the experience for carers of this often very upsetting situation. Eventually, I hope to develop a therapeutic intervention for children and carers which will help to prevent such disruption.

I expect this interview to last for approximately an hour, but it may take longer. I won't let the interview run for longer than 90 minutes, if that's ok with you. As already agreed, I'm going to voice record the interview, which I will switch on now. (Speak name of interviewee, date and time into the dvr.)

How long have you been working with your organisation?
And what were you doing before you did this job? (Maybe ask generally how they ended up doing this and if they enjoy it.)

How long had you been working with these carers before (child in question) was placed with them?

How would you describe your relationship with the carers? (Did you feel you had a good working relationship?)

What did you know about (child in question) before s/he was placed with the carers?

Do you think that background information on a child is important or necessary for carers?

How was (child in question) brought to carers' home? (Were you involved in the move?)

How did you feel about the timing of this placement for the carers?

How do you think the child felt about moving to the carers at this point in time (if child very young explore this by how the child reacted/behaved).

How soon after the child moved in did you meet him/her?

What were your first impressions of the child?

Did these impressions change?
When did you become aware that things were not going well (or that there was a problem) within the placement?

Seek information about the presentation of the child, behaviour, anything worrying or concerning.

Did you have any ideas why the child was like this?

Of the behaviours described, which do you think most affected the carers? (Why do you say this?) How do you think the carers felt about this behaviour (name specific behaviour, going through several if necessary)?

What did you do at the time?

How would you describe the carer's relationship with the child (foster mum and dad separately)?

What was the emotional atmosphere in the home like?

Did you notice if this situation had any effect on other family members?
Did the other family members have an effect on the child?

Was there anything which made your task difficult at the time?

Did you feel you were able to fulfil your role as a supportive person, able to share your knowledge and experience? Were the carers open to this? Were they able to reflect on the situation and what you were saying?

Looking back on it now, would you have done anything differently?

How has it been doing the interview today?

End interview: thank the participant for their time.

Placement breakdown in foster care with children under-five: A psychoanalytic view of the caregiving relationship under stress.

INTERVIEW SCHEDULE (for social workers)

Introduction: Thank you for agreeing to be interviewed as part of my research project. As I wrote in the information sheet, the aim of the research is to understand something about the process of placement disruption or breakdown, particularly when this happens unexpectedly and with very young children. I hope to understand something of the experience for carers of this often very upsetting situation. Eventually, I hope to develop a therapeutic intervention for children and carers which will help to prevent such disruption.

I expect this interview to last for approximately an hour, but it may take longer. I won't let the interview run for longer than 90 minutes, if that's ok with you. As already agreed, I'm going to voice record the interview, which I will switch on now. (Speak name of interviewee, date and time into the dvr.)

Lead-in questions:-

I'd like to hear about (child in question) and his/her time when staying with carer x, but before we go into that I have a few questions about how the child came to be living away from home (using the questionnaire).

How long had you known the child for before the move to this placement?

Can you recall why (child in question) was accommodated?

What were the social work plans for this child (i.e. to remain in foster care, adoption, or rehabilitation to birth family)?

Do you feel that you knew the child and his/her background well at the time?

Do you feel that you had enough knowledge about the child's specific needs at the time?

Was (child in question) moved to this carer on a planned basis?
Can you remember how (child in question) felt about moving to carer x? (Or can you imagine how this child felt – if child is very young).

Do you have any idea how the carer felt about this child being placed with them?

How often did you visit the child while at this placement? Did you stay in the home with him/her or take him/her out?

What were your impressions of (child in question)? (What was your immediate response on meeting him/her? How would you describe the child's personality?)

Did these impressions change?

At the time, what were your main concerns about (child in question)?

How would you describe your relationship with (child in question)?

What did you like about (child in question)?

How would you describe your relationship with carer x?

How would you describe the relationship between the child and the carer?

What do you recall about how this child fitted into the carers' home? How did s/he get on with the adults in the house? With any other children in the house?

When did you become aware that things were not going well?

At the time, did you have any ideas about why these difficulties had arisen?

What did you do at the time?

What support did you have? Did anyone offer help or advice?
Can you think of any help or support which would have been helpful to you at the time?

What finally brought the placement to an end?

Looking back on it now, do you think you would have done anything differently?

How has it been doing the interview today?

End interview: thank the participant for their time.

Placement breakdown in foster care with children under-five: A psychoanalytic view of the caregiving relationship under stress.

Factual details to be gathered from social worker:-

- Age and gender of child
- Any siblings and place in family
- Placed with siblings or not
- Dates of this placement – start and end
- Any previous periods of accommodation/number of previous placements
- Any periods of registration on Child Protection Register
- Any contact with birth family; if so, frequency.

Is there a known history of:	YES	NO	DON'T KNOW
Physical abuse	☐	☐	☐
Sexual abuse	☐	☐	☐
Neglect	☐	☐	☐
Domestic violence	☐	☐	☐
Drug or alcohol abuse	☐	☐	☐
Parent with a history in care	☐	☐	☐
Parental mental ill health	☐	☐	☐

APPENDIX FOUR

This is an example, taken from Case One, to demonstrate the process of analysing data using IPA.

In the first column is a word or phrase selected to describe how I have understood the material. This is from Stage 2 of the process, after the initial noting in the margin, when I created a more abstract concept to gather together the ideas from the initial noting.

The second column shows verbatim extracts from the interview.

The third column indicates the page and line number from the interview.

The headings are the super-ordinate themes, created from the clusters of ideas in Column One.

As can be seen from the final presentation of Case One, ‘Communication’ has been incorporated into ‘Process of the Interview’, and some of the themes, e.g. ‘Fostering Role’ and ‘Differences of Opinion and Complaints’ have taken a less prominent place than other themes, e.g. ‘Carers’ Experience of Looking After Child’. This was part of the process of prioritisation.

COMMUNICATION

Emergent Themes	Original Transcript	Page/line
• Good, clear description	like a high-pitched scream and just uncontrollable, constantly hands and arms (moves her arms up and down in a flapping motion to demonstrate) and high pitched scream.	4.28
	He loved to laugh…a smashing wee boy, he loved other children	8.14
	He could be a fun wee boy, watch cartoons, the cowboys – 'yeeha!'	18.31
• Struggle to communicate		
- beyond words	'just…'	8.16
	Not putting into words why they chose to foster.	1.19
- beyond understanding	'he felt a wee bit threatened'	6.40
	'he could be, aye, but just…'	9.15
	'whatever' 'I don't know, just…'	11.28
	'I don't think they actually knew how to control his screaming'	16.33
- inexplicability	Breathes in to express shock (shoes three sizes too small)	7.21
	two-seconds silence (cheese sandwich but not meat)	10.01
	food – 'that was a puzzle to me'	12.41
	'the food situation I just, I couldn't grasp'	12.42
	'no idea where that came from'	13.18
- not knowing	Two-second silence (puzzled)	10.01
- feelings contained in gasps and silences	'oh jeez' (fell on top of P)	5.11
	Four-second silence	10.09
	Four-second silence (after I articulate that he was injured in a sensitive place)	12.12
	Five-second silence (no other reason for end of placement)	19.04
	'whof' (kicking off)	4.24
	Four-second silence (possible criticism of s/w)	24.3
	Seven-second silence	7.2
	Four-second silence	9.8
	Trails off at mention of injuries	10.31
	'fathom'	13.9
	'imagine'	13.13
	Two-second silence	15.5 15.7

• Explanation		
- searching for meaning		
- searching for explanation	which meant he couldn't walk very well	3.12
	'might have been related to accident'	4.06
- making an assumption		
• A space for thinking and feeling	'the in-between bit'	11.24

Unconscious communication

• Transference and countertransference	'my goodness' (researcher)	8.07
	'I'm going to throw you out'	8.10
• Projection	'she was *terrified*'	4.35
• Moving away from feelings of distress	shifts from distress of screaming to poor walking	5.01
• Defences against pain and distress	other child's feelings – not theirs	4.35
	4 x 'nothing' follows my question re first impressions	7.08
	(laughing) child's fear of being alone	9.07
	'got to train him here, got to learn' (action)	10.27
	'we can work on other parts' (action)	10.35
	Routine-based approach/not thinking about child's distress	11.12
	'it's got to be done'	12.29
• Defences against not knowing or understanding	my probe about high pitched screaming leads to change of subject – medical cause	17.02

CARERS' EXPERIENCE OF LOOKING AFTER CHILD

Positive, rewarding feelings

• Empathy	'he just wanted love'	6.39
	'he felt a wee bit threatened'	6.42
	'he was used to being the baby in the family'	6.44
• Pride, achievement	'I taught him that one' (cowboys)	18.40
• Predictability	'you knew it was coming'	13.25
• Confidence	'you knew it was coming'	13.25
• Previous experience of successful foster placement	had two children for four years	1.40
• Searching for positives	'in fairness there was one night he was not a problem'	4.14

Confusion – 'unfathomable'

• Puzzled, bewildered	'and yet he would eat pasta'	9.41
	He would eat a sandwich and cheese but not a sandwich and meat	10.01
• Unpredictability	'you just never knew the minute'	16.03
• Out of their depth	'I just couldn't fathom that'	13.09
	'no idea where that came from'	13.18
• Uncertainty	'I don't know if…'	2.32
	'I might be wrong'	2.33
	'something about' 'or something'	2.38
	'I don't know' 'something tells me'	3.02

Difficult or frightening feelings

• Feeling annoyed	'that used to really annoy me'	18.24
• Feeling overwhelmed	'he's screaming there and she's screaming here and…'	4.45
• Fear and terror	'I was quite frightened about that'	5.07
	'I got the fright of my life'	14.04
	'I got the fright of my life'	14.37
• Panic, not in control	'I think I started to panic'	15.36
• Living in constant fear	'you just never knew the minute'	16.03
• Disabled	'you're working blind'	11.30
• Confidence undermined/ disillusionment, disenchantment	'and we said, that's great, we've got him, he's coming round to it, a wee bit, then the next night he just kicked off again.'	4.16

Sadness and Loss

• Sadness, regret	‘we didnae have that time’	10.38
• Mourning the loss of previous children	This came out very strongly once the DVR was switched off and they began to talk about the children who’d moved to adoption earlier that year. H became tearful (and was confirmed by SSW)	
	‘Two of them were actually four years, brother and sister we had for four years.’ (I wonder if this is a sign that they’re still on her mind?)	1.40

Anxiety

• About my question	they answer immediately ‘yes’ when I ask about their ‘good parent’ role	18.04
• About the interview	Before DVR switched on, H expressed anxiety.	
	At the end of the interview, H expressed surprise – ‘is it?’	18.28

CHILD’S EXPERIENCE

• Fear	‘he had a fear, a fear of a lot of things’	3.45
	‘he had a terrible fear of the bath’	4.02
	‘he didnae want to be in here by himself’	9.01
• Extreme distress	vomiting	9.33
	A panic	11.26
• Scattered, not held together	‘his legs was all over the place’	7.14
	‘just different bits all over the place’	10.06
• Propelled into new and unfamiliar situation/position	‘he was always used to being the baby in the family’	6.44
• Rejection: of food; of nurture	Vomiting	9.33
• Need for love	‘he was a lovely wee boy, and just wanted love. He really did.	6.39
• Neglect	‘just sat in front of the television in a pram’	3.08
	‘watching the television all day’	3.11
	‘she apparently done a lot of work with him’	3.28
• Developmental delay	‘He wasn’t toilet trained’	3.36
	‘well, he’s a bit, a bit slow’	10.21
• Damaged child	‘there’s something wrong with him’	14.39

INFORMATION, KNOWLEDGE, FACTS (and absence of these)

• Lack of information	'I think there was maybe an abuse'	2.26
	'I don't know the ins and outs of it all'	2.44
• Being kept in the dark	'we were getting fed wee bits at a time'	19.21
• Information not given in time	not told about 'clumsy syndrome'	5.16
• Knowing something (leading to confidence)	clear about him not being toilet trained	3.36
• Uncertainty	'I don't know if…'	2.32
	'we don't know'	4.10
• Vagueness	'something about the gran' 'she was drunk or something'	2.38 2.39
	'doon below'	7.32
• Making allowances (for lack of information)	'in fairness, it was an emergency'	5.37
	SSW also being fed 'wee bits at a time'	19.23

OTHER CHILD(REN)

• Concern for other child	'she was my concern'	15.17
	'P's safety'	18.46
• Inability to keep other ` child safe	falling on top of P	5.06
• Failure to protect other child	as above 5.06	
• Need for safe caring	'you're looking at the safety aspect of it'	15.43
	'Basically, it was a case of safety, for the wee yin'	19.08
• Risk/danger	as above 5.06 and 5.07	
(safety vs danger)	'she was really at risk of getting hurt'	19.01
• Foster children secondary to birth children	'obviously C took preference to a foster child'	1.15

FOSTERING ROLE

• Reasons for fostering		1.10
• Difficulty in performing essential parenting task	delay (speech, walking)	10.18
	the injury	10.30
	the eating problem	14.19

SUPPORT

• Practical vs. emotional support	'that would of really benefited him' (nursery)	8.24
	SSW trying to get nurseries (when I ask about support)	16.16
	'just the nursery would have been ideal'	17.20
• Getting on with it	'getting on with the next stage of it'	16.21
• No support	no complaint or expectation of this	16.11
• Looking for support from partner/paired dialogue	Tell story together	2.32-
	Finish each other's sentence	3.30
	Looking to husband for back-up	3.45
• Demands on carer time	'so would he be'	9.05

DIFFERENCES OF OPINION AND COMPLAINTS

• Different interpretation of child's behaviour	'I mean he wasn't shy'	7.09
	HV tells them 'this is all due to the condition as well'	17.30
• Physical vs. psychological or emotional explanation	the physical injury has led to his poor walking, rather than neglect	7.32
• Complaint/criticism	'nobody said he had a brother like that'	5.24
	'whether they tried hard enough or not, I don't know'	8.23

APPENDIX FIVE

This is an example, again taken from Case One, to show how I grouped the clusters of ideas under sub-headings and main headings, leading to the development of super-ordinate themes.

COMMUNICATION

a) Verbal

- Explanation
- Good, clear description
- Description of neglect

b) Non-verbal

- Something not expressed – holding back
- Feelings contained in gasps and silences
- Beyond words

c) The struggle to express something

- Searching for an explanation
- Vagueness
- Beyond understanding
- Beyond the help or understanding of anyone
- Inexplicability
- A space for thinking and feeling

d) Unconscious communication

- Transference and countertransference
- Projection
- Moving away from feelings of distress
- Defending against pain and distress of child
- Defending against own feelings/Action vs thinking and feeling
- Defences against not knowing or understanding
- Anxiety about my question (what it might mean)

CARERS’ EXPERIENCE OF LOOKING AFTER CHILD

a) Positive, rewarding feelings
  - Empathy
  - Pride, achievement
  - Predictability
  - Confidence
  - Previous experience of successful foster placement
  - Searching for positives

b) Confusion – ‘unfathomable’
  - Disabled
  - Puzzled, bewildered
  - Unpredictability
  - Not knowing
  - Out of their depth
  - Uncertainty

c) Difficult or frightening feelings
  - Feeling annoyed
  - Feeling overwhelmed
  - Consumed by distress
  - Fear and terror
  - Panic, not in control
  - Living in constant fear
  - Confidence undermined

d) Sadness and loss
  - Sadness, regret
  - Disillusionment, disenchantment
  - Mourning the loss of previous children

(*NB: how most, if not all, of these are true for the child as well.)

CHILD’S EMOTIONAL EXPERIENCE

Fear
Fear of being alone
Extreme distress
Scattered, not held together
Propelled into new and unfamiliar situation
Rejection: of food; of nurture
Neediness
Need for love
Neglect

INFORMATION, KNOWLEDGE, FACTS (and absence of these)

Lack of information
Being kept in the dark
Information not given in time
Knowing something leading to confidence
Uncertainty
Making allowances (for lack of information)

OTHER CHILD(REN)

Concern for other child
Inability to keep other child safe
Failure to protect other child
Need for safe caring
Risk/danger
Foster children secondary to birth children

FOSTERING ROLE

Reasons for fostering

Difficulty in performing essential parenting task

SUPPORT

Practical vs emotional support

Getting on with it

No expectation of support

No support

Looking for support from partner/paired dialogue

Demands on carer time

DIFFERENCES OF OPINION AND COMPLAINTS

Different explanation than that of carers

Difference in interpretation of child's behaviour

Physical vs psychological or emotional explanation

Complaint/Criticism