Challenges Facing Long-Term Foster Carers:

An Exploration of the Nature of Psychoanalytic Parent/Carer Support

by

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Abstract

This research study investigates the role and impact of psychoanalytically-informed short-term parent work with long-term foster carers of looked-after children, in support of the foster placement.

The study reflects on the data gathered from four child assessments and five foster families seen by a psychoanalytic child psychotherapist for four sessions each. It draws on psychoanalytic ideas from a range of theoretical traditions, exploring such concepts as trauma, defences, compulsion to repeat, psychological-mindedness, 'container/contained' (Bion) and 'holding environment' (Winnicott).

One distinctive contribution of this research is what it adds to our already existing understanding of the defences (or responses) aroused in the carer when faced with the intense and distressing affect associated with the child's early trauma; and the impact of this legacy of trauma on the child, on the carer and on the wider Social Services system.

Applying Grounded Theory and psychoanalytically-informed clinical case study methodology to the research material, the study breaks down the data analysis into seven stages of coding, from the initial reading of the data to the eventual development of two key hypotheses. One of the predominant themes that emerged from the analysis was the carer's capacity to remain focused on the child's emotional needs and how this in turn was linked to the direction of the therapist's focus. The successive analyses of the data culminated in the hypothesis that the more the therapist focused on the carer and the carer's emotional states in the course of the parent work, the more the carer was enabled to focus on the child's emotional needs.

As the system of categories emerged according to the themes exemplified in the sessions, a particular focus of analysis became the concept of psychological-

mindedness, considered under several sub-categories: displaying insightful comments; awareness of the child's bodily states; awareness of the child's affect; the carer's ability to recognize the child's defences; and the carer's ability to make links between the child's current difficulties and the child's past experiences. Through this analysis it became apparent that degree of psychological-mindedness was closely linked to the individual carer's capacity to metabolize the child's distressed and distressing communication. This in turn led to a deeper exploration of the situations that were particularly challenging for the carers: i.e., instances when the child was compelled to repeat past traumatic emotional states and as a result was communicating intense distress. This exploration eventually generated the second hypothesis: that in reaction to the child's distress, the response of each carer could be plotted somewhere along a spectrum, from either distancing themselves from the child's emotional state to seeking excessive closeness with the child (merging). The next stage of the analysis developed four new categories of carer responses to the distressed child: identification and distancing from the child; identification and merging with the child; the category that describes the carer's psychological-mindedness as being 'impaired'; and 'good enough' caring. This then led to an exploration of the carer's own defences at these most challenging times.

This research demonstrates clearly that even within the short space of four sessions of weekly psychoanalytic parent work, it is possible to achieve significant improvement in a carer's capacity to bear the child's compulsion to repeat early traumas, and to help the carers become more emotionally available to provide the child with effective psychological parenting at such difficult and challenging times.

Key words: *looked-after children; long-term foster carers; psychoanalytic short-term parent work; trauma; compulsion to repeat; psychological-mindedness; empathy; defences; psychoanalytically-informed clinical case study research methodology; Grounded Theory research methodology.*

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Chapter 1: Introduction

Introduction

According to the website of the Northern Ireland Department of Health, Social Services and Public Safety, 66 out of every 10,000 children are 'looked-after'. According to the Fostering Network statistics of children in care (Tears, 2014), in 2014 over 63,000 children were living with almost 55,000 foster families across the UK each day. Around 30,000 more children come into care over the course of 12 months. These statistics illustrate some of the pressures on the Social Services providing support for looked-after children (LAC). Foster carer families are a very scarce resource, and the sustainability of the placements of looked-after children has more than ever become a priority. This research project explores the contribution made by the psychoanalytic child psychotherapist in supporting these placements, with a particular focus on the benefits of psychoanalytically-informed parent work with the foster carers.

This research study took place at the Family Trauma Centre (FTC) in Belfast, a specialist CAMHS (Child and Adolescent Mental Health Services) facility that provides treatment for children and their families suffering from the effects of trauma. For the child psychotherapists in this clinic, a high proportion of their patients are children in care and their foster carers. The FTC is a regional service, serving all of Northern Ireland. In this region, as of 31 March 2014 (Tears, 2014):

- 2,156 children were living with foster families (England 51,340; Scotland 5,533; Wales 4,405)
- This is more than four-fifths (86 per cent) of the 2,501 children in care being looked after away from home
- There are approximately 2,060 foster families in Northern Ireland
- The Fostering Network estimates that fostering services need to recruit a further 170 foster families in Northern Ireland in the next 12 months.

Due to the lengthy and time-consuming process of gaining ethical approval (with a separate approval procedure required for each Health & Social Services Trust), this study recruited participants only from the area of the Belfast Trust, which, according to the Department of Health, Social Services and Public Safety website, in 2014 was caring for 721 children.

However, LAC services are not exceptional in being subject to immense budgetary pressures. In the current financial climate in the NHS, a psychotherapist seeking to draw up a treatment plan for a child patient and the child's family is under serious pressure to compromise with respect to the use of resources, especially regarding the frequency and length of the treatment. A particular example of this pressure on services is psychoanalytic work with parents and carers. In the context of multidisciplinary teams, psychoanalytic child psychotherapists are required to provide on-going evidence to justify the time spent supporting the families of child patients. Although there has been extensive consideration of parent work in the psychoanalytic literature, one aim of this research is to contribute to bridging the gap between the world of psychoanalytic theory and practice and the wider care system.

This research study investigates the role and impact of psychoanalytically-informed short-term parent work with foster carers of looked-after children (LAC), in support of the foster placement.

The study will reflect on the data gathered from four child assessments and five foster families seen over a total of four sessions each.

There were initially two research questions:

- **'What is the nature of short-term psychoanalytically-informed parent/carer work?'**
  and
- **'What impact does short-term psychoanalytically-informed parent/carer work have on the foster placement?'**

As the investigation unfolded, through the application of Grounded Theory research method, more specific questions (and answers) emerged from the data:

- What are the recurrent issues brought by the carers in this study for consideration in short-term psychoanalytically-informed carer support work? (See Chapter 7.2.)

- How do the carers in this study communicate their degree of psychological-mindedness in relation to the children in their care, and what are the obstacles to the carers remaining psychologically-minded when parenting a child in their care? (See Chapter 8.1.)

- What difference did four sessions with a child psychotherapist make to how these carers view and respond to their foster child? (See Chapter 8.3.)

- What is a psychoanalytic understanding of the carer's responses to the child's communication of distress or trauma? (See Chapter 8.5.)

- What is the role of the child psychotherapist in supporting carers who care for children who at times present with disturbed and disturbing behaviour and/or moods? (See Chapter 8.6.)

One distinctive contribution of this research is what it adds to our already existing understanding of the defences (or responses) aroused in the carer when faced with the intense and distressing affect associated with the child's early trauma; and the impact of this legacy of trauma on the child, on the carer and on the wider Social Services system.

Chapter 2: Structure of the Dissertation

Structure of the Dissertation

The dissertation contains the following chapters:

- '**Selection of the participants**' describes the process of selecting the participants, as well as providing an introduction to each of the families and their foster child. Although this research project focuses on the common themes and patterns shared by the participants, this chapter is particularly important in offering a glimpse of the great variety of individual qualities of the carers and the children, and their needs as presented in the psychoanalytic parent support work.

- The '**Research ethics**' chapter provides an account of how permission was obtained from the research participants and reflects on the process of obtaining ethical permissions, from various interested bodies, to carry out the research, as well as the steps taken to ensure the confidentiality of the carers and children in this study.

- The '**Literature review**' chapter provides an overview of the historical development of parent work and the issues commonly presented by carers in parent/carer support sessions with psychoanalytic child psychotherapists. It also looks closely at the psychoanalytic concepts of trauma, compulsion to repeat, psychological-mindedness, empathy and defences, from a variety of theoretical perspectives. Throughout this chapter, these concepts are considered within the relational psycho-dynamics of foster carers, foster children, and a clinician/researcher.

- The '**Research methods literature review'** chapter considers the suitability of clinical case study methodology, in combination with Grounded Theory, as the chosen methods for gathering and analysing the data in this research study.

- The '**Analysis of the data'** chapter is a step-by-step guide through the several stages of coding developed through the course of this research, and it

demonstrates the processes by means of which hypotheses were brought forward and tested against the research data. This chapter should be considered in conjunction with the chapter on findings.

- The chapter on '**Findings**' consists of a series of findings that emerged from the data analysis. This chapter details the impact of four psychoanalytically-informed parent support sessions on the carers' psychological-mindedness with respect to a child in their care; and also investigates some particularly challenging aspects of foster care, when the carer is faced with the child's compulsion to repeat his or her past traumatic experiences and mental states.

- This is followed by a chapter on '**Recommendations for further research**', which points to ideas that emerged from consideration of the data but, owing to the time constraints of this study, could not be followed up. These considerations draw attention to some significant topics in the life of foster carers and the children in their care. The chapter also suggests a possible correlation between the defences of foster child and carer, with some additional data analysis that might be interesting to pursue in further research.

- The '**Conclusions**' chapter brings together the main findings of this research study and suggests possible implications and applications of these findings to policies and procedures governing the long-term foster care of looked-after children.

Chapter 3: Selection of the Participants

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- Background as reported by Social Services
- Referral
- First impressions of Cameron
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Selection of the Participants

- **Meeting the referrers**

The following section will give a short summary of the process of selection of the participants in this research.

Once permissions were obtained from the relevant research ethics committees and the local Health and Social Care Trust, a meeting was arranged with the Trust's LAC Services management team, to discuss the benefits of this research project, in the form of short-term support for the foster carers currently providing homes for five looked-after children.

This resulted in a follow-up meeting with all the senior social work practitioners of the local Trust's LAC Services, as potential sources of referrals of the research participants. Prior to the meeting, a written summary of the research proposal and design was sent to the management team. During the meeting, the outline of the research project was explained and the meeting participants were offered an opportunity to ask questions and briefly discuss the potential candidates.

The selection criterion for the project was:

An individual foster carer or foster carer couple currently parenting a looked-after child (aged 4-11) in a (non-kinship) long-term placement.

This criterion was chosen to minimize as far as possible the variables among the children, such as major developmental milestones, transition to secondary school, or the circumstances of the placement, i.e., short or long, kinship or non-kinship.

- **The participants – the foster children**

As a result of these meetings, five families were referred to the project over a period of three months. The referrals consisted of a mix of three boys and two girls, aged from 6 to 11.

All the children's birth mothers had either diagnosed (4) or undiagnosed (1) significant mental health difficulties, which were, in some cases, trans-generational, and included psychotic episodes, suicide attempts, and substance abuse that resulted in physical and/or emotional abuse and neglect of their children.

Four of the children did not know who their birth father is and one had been told (untruthfully) that his birth father is dead. All of them, at some stage, had shared a household with their birth mother's male partner(s), some of whom were known sex offenders and/or otherwise physically violent.

On average, the children remained in their birth mother's care up until the age of 6. All of them, at the time of assessment, had regular contact with their birth family.

- **The participants – the foster carers**

All five foster families consisted of foster mother and foster father, of which five foster mothers and only two foster fathers attended the sessions. All of the foster couples had older children of their own and had previous experience of fostering, but none of the couples had younger children of their own.

- **Involvement with the families**

Written information sheets and participation consent forms were sent to the children and their carers in advance of the initial meeting with the researcher (see Appendix 1).

The initial meeting took place with each foster carer or foster carer couple and their referring social worker. The aim of the initial meeting was to discuss the aims of the research project and to allow the participants to gain further knowledge about the project before making their decision to take part. All participants, including the children, were offered an option to withdraw their participation in the research project at any stage, with the option of continuing the sessions with the psychotherapist if they wished.

Following the meeting between the carers, the social worker and the researcher, a state of mind assessment of each child was carried out by the researcher over a period of three individual, weekly sessions.

This was followed by four weekly psychoanalytically-informed parent/carer support sessions with each set of carers. These sessions were audio recorded and later transcribed.

The sequence was concluded by a feedback meeting with each foster carer or foster carer couple and their referrer. A written state of mind assessment report was provided in relation to each child. (For an exception to this, see Cameron below.) In some cases, a recommendation was made for further therapeutic work.

The following section will provide an introduction to each research participant and their families as reported by them and their referrers; and will include the early impressions of the researcher.

Anna (C1) and Mrs & Mr Morgan (FM1 & FF1), her foster parents

(All names have been changed in the interests of confidentiality.)

Background as reported by Social Services

Anna, aged seven, is a looked-after child. She is the youngest child in a family of three. She has a 14-year-old sister and a 12-year-old brother. Anna's birth mother suffers from long-term mental illness that manifests as suicidal ideation, psychotic episodes, and substance misuse, with the result that Anna and her siblings suffered chronic neglect and multiple house moves. Anna's birth father's name and whereabouts are unknown.

Anna was initially placed with the Morgan family at the age of 5. Her sister went to live with her maternal grandmother and her brother ended up in a children's home, owing to his challenging behaviour. Anna's placement became long term a year after the initial placement, with an expectation that Anna would return to her birth mother's care in due course. The agreed frequency for supervised family contact is fortnightly and the telephone contact twice weekly. Anna has regular respite with her maternal grandmother. The Morgans have a 17-year-old daughter of their own, who shares the household with Anna.

Referral

The referral described Anna as a child who assumes an adult role during her contact with her birth mother: for example, defusing conflict situations and being anxious about her mother's ability to cope with Anna being in care. Normally a placid and happy child, Anna was also described by her social worker and by Mrs Morgan as showing some 'out of character behaviour', such as mood swings, following the contact, at such times being emotional, angry and tearful. In school, Anna was described as inquisitive, eager to learn and overall a popular child, although she had been known to bully other children in the past.

First impressions of Anna

Anna, aged 7, was of slight build, with big, dark blue, sad-looking eyes and a faint voice. It was noticeable that her hair needed a wash and her school uniform was stained and wrinkled. Although my first impression of Anna was one of an eloquent, cautious and compliant little girl, I also observed that outside the consulting room, in her interaction with Mrs Morgan, Anna tended to display a strong sense of rivalry. She would request that Mrs Morgan race her to the car and would laugh at her being slow and clumsy.

Over the three sessions of the assessment, I found Anna to be an intelligent girl, remarkably imaginative and opinionated, especially on subjects of ecology and vegetarianism. The main area of her difficulties seemed to lie in her overly mature attitude, which at times, I felt, could be perceived by others as arrogance, or her struggle to acknowledge the child/adult dynamics in a relationship. To an outsider, Anna could convincingly give the impression of an easy-to-care-for child who is doing well and needs no help from others. However, at closer look, it was clearly evident that she struggled to seek support and guidance in an age-appropriate way, yet longed to be understood by others. I could see how easily her deeper underlying feelings could go unnoticed, accumulating and fermenting as a result. This is especially true in relation to negative, rougher and more difficult feelings, as they tended to come out in sudden and subtle ways, such as unexpected acts of unkindness.

Mrs & Mr Morgan

Mrs Morgan, in her 60's, was about five feet tall, a curvy woman with big, shoulder-length hair. She tended to wear long skirts and shiny beads that reached her waist. Every session she came with a book in her hand, usually a bestseller of some sort. She was disabled from birth, with only one functioning arm; and although her physical movement was practically unrestricted, during our sessions I often wondered about the impact her disability had on her mind, particularly when I listened to her views on Anna. To be precise, I wondered how she had been seen in her own mother's eyes as a baby. I also felt her disability played a role in her struggle to acknowledge Anna's birth mother's limitations.

Mrs Morgan spoke with a broad accent, peppered with local sayings. At times her sentences would stop mid-way or flow into each other. She also tended to repeat herself. The social worker described her as someone who is 'happy to attend any trainings', but from our first meeting I felt I was experienced by Mrs Morgan as someone potentially persecutory. On one occasion when the tape on the tape recorder had run out prematurely, Mrs Morgan sighed with relief, commenting on how uneasy she had felt with the sessions being recorded.

Mr Morgan chose not to take part in the study. The link social worker reserved her views. According to Mrs Morgan, Anna tended to avoid engaging with him unless absolutely necessary.

Madison (C2) and Mrs & Mr Woods (FM2 & FF2), her foster parents

(All names have been changed in the interests of confidentiality.)

Background as reported by Social Services

Madison, aged 6, is a looked-after child. Her birth mother suffers from schizoaffective disorder and has a history of sexual abuse. As a little baby, Madison bore witness to her mother's depressive episodes with psychotic features. The family had several house moves. The Social Services reports stated that her mother tended to smack Madison and expose her to adult sexual encounters. On occasions, Madison was left in the care of a known male sex offender.

There is no information available about Madison's father.

Aged 3, following her birth mother's hospitalization, Madison was placed in short-term foster care, then one month later she was moved to respite, and a few days after that she was finally placed in a long-term placement with Mrs and Mr Woods, on a voluntary arrangement. Mrs & Mr Woods have two older daughters and a son of their own, who live separately.

Following her placement, Madison's birth mother had repeated hospitalizations. During those times, visits did not take place, as her mother was too unwell. Madison refused to speak to her mother on the phone, or said very little. She did not mention her mother during her absences. Instead, she had short periods of unsettled behaviour and complaints of sore tummies for no apparent reason. Once her mother's mental health improved, the contact resumed.

Madison was 4 when her mother became pregnant with Barry, Madison's half-brother. During this time, Madison was diagnosed with enuresis. Unsuccessful attempts were made to send Madison back into her mother's care in a phased manner, but she continued to have fortnightly contact with her birth mother and her half-brother. According to her social worker, she frequently enquired about returning to her mother's care and struggles to understand why she is still in care.

Referral

The referral was made by a senior social worker, who stated that Madison had a tendency to worry excessively about her birth mother, showing some behavioural difficulties when her mother was having relapses in her mental health and general functioning. The referral stated that Madison tends to be defiant, lacks boundaries, and can be aggressive towards other children. School had remarked on her struggle to follow instructions.

First impressions of Madison

Madison, aged 6, had a round face, two pigtails and piercing blue eyes. Her hair bobbles were handmade to match her uniform and gave her a doll-like appearance. She was an energetic child. Her voice was husky and loud, and she tended to speak continuously without pausing or fluctuating in volume or tone. Madison gave me the impression of an intense little girl.

Mrs Woods was an attractive-looking woman in her early 60's. She was well groomed and elegantly dressed. Her tone of voice was pleasant and she spoke sparingly. This was in stark contrast to the way Madison presented.

On our first meeting, Madison seemed to have no outward reluctance to follow me to my room. There was an air of manic appeasing in the way she related to me, indicating extreme anxiety. This had an unsettling quality to it, making me think of the un-boundaried behaviour of the adults I had read about in her referral. I asked Mrs Woods if she could join us until Madison got used to me and the room. In the room, Mrs Woods and Madison began speaking simultaneously. I waited a moment to see how this would unfold, but strikingly, neither seemed aware of it. I wondered whether this had been confusing for Mrs Woods, who was to be the beneficiary of the assessment. I found myself struggling to link them up, but my attempts to engage one with the other were ignored. Neither made any reference to the other, as if they were not in the same room. Within a few moments, Madison had written her name on the page, using a different colour for each letter. I remarked on how each letter had a different colour, but Madison stated confidently and without hesitation that she always writes her name like a rainbow. Shortly after, Mrs Woods was able to leave the room.

Once on her own in the room, Madison was able to use play to indicate some of her underlying anxieties. This was very hopeful. However, she tended to involve herself in multiple activities simultaneously, struggling to sustain one for any period of time. When I showed interest in her play, she avoided me, by changing her activity or by retreating into solitary play. When she eventually made attempts to engage me, this had a repetitive and adhesive quality to it. Madison frequently used seemingly shallow and false attempts to empathize with her dolls, telling them that they will be all right. It was clear that the intimacy of a small room and one-to-one adult attention was a lot for her to manage, and she could only cope with it by resorting to extreme defences, such as omnipotence, a high level of activity, and at times even dissociation.

She showed all the signs of a child who struggles to make use of another. This seemed to indicate some significant developmental deficits stemming from the times when her birth mother was not available to her for effective parenting.

Mrs & Mr Woods

During the work, Mrs Woods cancelled four sessions. She accounted for this by reference to her father's ill health. In her sessions, she seemed reluctant to speak, explaining that she would rather hear what I had to say. She never took her coat off. Only towards the end of our work did Mrs Woods admit that she had found some of the links between Madison's ongoing struggles and her early life difficult to bear. During our sessions, she often referred to Madison's birth mother as being the same age as her own daughter, and seemed to identify with her difficulties at times at the expense of Madison's needs.

Mr Woods, according to his wife, was not interested in taking part in this project and was somewhat absent from family life altogether. She jokingly commented that the only thing he is interested in is his pigeons. They had three grown-up children of their own, and a year after Madison's arrival they have become grandparents for the first time.

Tony (C3) and Mrs & Mr Winters (FM3 & FF3), his foster parents

(All names have been changed in the interests of confidentiality.)

Background as reported by Social Services

Tony was almost 7 years old at the time of the referral. He was born the youngest in a family of eight. His family had a complex and turbulent trans-generational history, involving violence, drugs and murders.

Tony's birth mother suffered from mental health difficulties, but she was never formally diagnosed; she was found to be unable to complete the psychiatric assessment. His father was only six years older than Tony's eldest half-sibling, and his mental health functioning was largely impaired by his heavy use of drugs. At the time of Tony's birth, his father was in prison for threats to kill and cause grievous bodily harm to his mother while she was expecting Tony. At the time of his birth, Tony was registered under the categories of potential neglect and potential physical abuse.

When Tony was 6 months old, his father was released from prison. Soon after, all the children were removed from the child protection register. Tony and Patrick, his one-year-older brother, were frequently looked after and physically punished by their older half-siblings. Further neglect and abuse were reported by his older siblings: for example, the time when Tony was scalded in the bath as a result of inadequate supervision. His birth mother chose to delay seeking medical help due to her concern that Social Services would be informed what had happened and become involved.

When Tony was one year and seven months old, his mother voluntarily placed him in care with Mrs & Mr Winters, along with his brother Patrick. However, within a matter of weeks the placement was truncated and the boys returned home. Owing to continuing concerns, Interim Care Orders were granted on all children, and as a result Tony and Patrick were returned to Mrs & Mr Winters, and subsequently a Full Care Order was granted.

Agreed frequency for the family contact is bi-monthly, with sibling contact on a monthly basis. All contact is supervised.

Referral

Tony was described by his social worker as a boy who has significant developmental delay, particularly where his learning capacity and comprehension are concerned. He suffered from distressing dreams and flashbacks that were also evident in his play, such as memories of being covered in his mother's blood or of his grandmother being resuscitated by paramedics. He also tended to soil and wet his bed. Tony had developed a particular interest in the subject of death and showed unusual interest in the pain of others. It was noted that Tony struggled to share or to empathize with others. His relationships at school were problematic. He also tended to inflict pain on himself: for example, he would bang his head against hard or sharp surfaces, spontaneously swallow staples, push the leg of a chair into his genitals, and so on. Mrs & Mr Winters were required to maintain high levels of supervision. He tended to lash out, at times with little or no notice, and on occasion this involved knives or scissors.

Mrs & Mr Winters described Tony as a very impulsive child. They recalled that for the first few years of caring for him he screamed in distress for several hours every day for no apparent external reason. Tony also had a diagnosis of epilepsy.

First impressions of Tony

Tony, aged 6, had wavy, dark auburn hair, a Greek profile and widely set, blue, almond-shaped eyes, all of which features made him look distinct from most of the local children. It also made me wonder about the possibility of foetal alcohol syndrome.

It was evident that Tony had warmth about him. He was not avoidant, but showed interest and was active in the room with me. He left an impression of an intelligent enough boy, but emotionally many ordinary things were puzzling for him and making links at times was overwhelming. Tony responded better when I communicated with him on a purely descriptive and mirroring level.

Tony presented as a severely traumatized boy whose early beginnings have obstructed his development at a fundamental level, so that his perception of the world was fragmented.

He spoke about and drew monsters. Some of his drawings were very particular: i.e., they depicted clothing and hairstyle; while others were abstract and shapeless. I

understood these drawings to be representations of his experiences, flashbacks of his desperate states of mind. His core self seemed absent, and instead there were multiple fragments, mostly of a malignant nature, making me think that there may be times when Tony identifies with them: i.e., taken over by the scenes of violence in his mind, he had the potential to become a violent 'monster' himself.

Tony gave the impression of a child with no sense of a continuous self, someone who depended on other people around him for his memory. For example, in the second session he did not recognize either his own drawings or me. Instead, he seemed to experience life on a moment to moment basis, each moment potentially catastrophic. This was evident in the room when at times he became overwhelmed by suspicion and fear. For example, during one of the assessment sessions, a drop of ink splashed on a page. Tony became terrified, telling me that it had come out of my mouth, that I spit 'black blood'. At other times, he would become terrified without attributing any of it to his external world, treating me simply as a benign witness.

However, it seemed like he was also making tentative attempts to build some sense of self. He wanted me to draw with him, but then suddenly he would become controlling of my drawings, to the point where he no longer drew himself. He seemed to have a notion of what it is like to be with another and he seemed to want it, but it quickly became too frightening for him, because of his past experiences. Even though he could thus far only manage to do this in a rigid way, I saw this as a hopeful sign. I attributed this potential to the exceptional quality of care provided by his carers.

Mrs & Mr Winters

Mrs & Mr Winters (both in their mid 50s) attended for the sessions as a parental couple. They kept acknowledging each other's views and referring to each other on a frequent basis.

Mrs Winters, with her kind and smiling eyes, radiated maternal warmth. According to her, she came from a big and happy home. She had a grown-up daughter from her first marriage.

Mr Winters was tall and slim. He came across as the quieter of the two. He had an air of naïveté about him. His own father had died when he was eight and he said that this had made him want to foster. His hobby was in motorsports, where he had recently injured himself, causing ongoing concerns for his health.

Together they had already adopted and raised two boys from overseas, also brothers, who were just about to leave the family home to further their education.

The approach of Mrs & Mr Winters to Tony's difficulties and needs was thoughtful and compassionate. It was evident that they were committed parents. However, it also became apparent that they seldom reflected on their own responses when encountering the boys' at times shocking and disturbing re-enactments of their earlier life: for example, when Tony stabbed their eldest son with a knife.

Kevin (C4) and Mrs & Mr Patterson (FM4 & FF4), his foster parents

(All names have been changed in the interests of confidentiality.)

Background as reported by Social Services

Kevin, aged 11, is a looked-after child. His birth mother had also been in care. She suffers from depression and was addicted to alcohol. She was 19 years of age when Kevin was born. Penny, his older sister, was born two years prior to that. Kevin's father was deemed to be unknown. He left the family before Kevin was born.

The family had several moves, living mainly in hostels. Kevin was two when the first concerns were raised regarding the conditions in which the children were living. Social Services became involved and discovered that Kevin and Penny were frequently abandoned in a locked room for long periods without food or toilet and with no adult in sight. Penny was diagnosed as having learning difficulties. A few months later, their younger half-sister was born. When Kevin was 4 years of age, he and his siblings' names were placed on the Child Protection Register under the category of neglect.

Kevin had just turned 5 when he and Penny went to live with their maternal grandparents. A year later, his birth mother raised concerns about the children remaining in her parents' care due to her own upbringing, and she agreed to the children being voluntarily accommodated by the Trust. With no prior notice, Kevin and Penny were placed with Mrs & Mr Patterson. As Mrs Patterson later described this transition, 'they went from their grandmother's home to school and came home to strangers'. Their younger half-sister was placed separately. Agreed frequency for the family contact is monthly and sibling contact is twice monthly. Mrs & Mr Patterson are also caring for an older boy with considerable learning difficulties.

Referral

The referral was made by the children's social worker. The referral stated that Kevin has always struggled with his feelings regarding being in care. However, his loyalties seemed to be divided between Mrs Patterson, whom he called 'nanny', and his birth mother. According to his social worker, Kevin appeared settled in his placement and

seemed to have a close bond with Mrs Patterson. He also tended to get angry with her, which manifested as screaming, crying, lying on the floor and kicking in frustration. Lately he had been making accusations about his carers hitting him. He was described as a boy who struggles to talk about his feelings and is unable to identify what triggers his anger. The referral attributed this to Kevin's young age and his frustration about being in care. In addition, Kevin had recently been transferred to a grammar school and was experiencing this additional pressure alongside normal early adolescent development. He was described by his social worker as emotionally fragile. It was felt that Mrs & Mr Patterson would benefit from some additional support in helping Kevin to channel his feelings, in order to stabilize his behaviour.

First impressions of Kevin

Kevin (aged 11) instantly struck me as a well-mannered, likeable and intelligent young man. He was tall and very slim. His face was hidden behind thick, unruly hair, making his head look out of proportion to the rest of his body. He told me he liked his hair long.

On our first meeting, he quizzed me thoroughly with various general knowledge questions, which I understood as his way of wanting to know whether he could trust my intelligence and trust me to contain him. It was quite plain that he did not trust me. His manner of conducting himself also indicated that Kevin is struggling to recognize child-adult relationships, and his omnipotence was further exacerbated by his knowledge that he is intellectually gifted and that this set him apart from other children; and, in his view, from most adults. He tended to communicate this in a rather arrogant manner. It was only in his play that I could see a much younger boy who was able to show me some awareness of deficits in his early beginnings. Although he could communicate his thoughts and feelings through his play, he also was communicating his need to pre-empt any possible disappointment, doubting that his exploits are worthwhile.

From his carers I learned that, although he was succeeding academically, Kevin struggled to make or keep friends. He tended to embarrass other children and because of that was not liked by his peers. At home Kevin tended to display a range of distressing, confused and confusing behaviours, such as licking the television or reflective wardrobe doors. He also tended to swear at his reflection in the mirror and

make spontaneous vocalizations. Mrs Patterson reported that at times she found him frightening, but there were also times when he would put his head on her knees and enjoy her stroking his head.

Mrs & Mr Patterson

Mrs Patterson, in her mid sixties, is eleven years older than Mr Patterson; however, the age difference is not obvious in their looks. Mrs Paterson wore heavy makeup and had short, copper-coloured hair. She spoke loudly and expressively, and tended to come up with generous, flattering statements. Mr Patterson, on other hand, looked somewhat grey in comparison. He spoke softly and there was a general air of tiredness about him. Mr Paterson himself had had an experience of adoption that both assisted and limited his understanding of Kevin's difficulties. He worked night shifts and was able to attend only two sessions.

In addition to having the three foster children, they are also busy grandparents to their grown-up children's offspring and keep in close contact with one of their previous foster sons who lives nearby. They had been fostering for years and had decided that Kevin and Penny will be the last children they care for.

Cameron (C5) and Mrs & Mr Stewart (FM5 & FF5), his foster parents

(All names have been changed in the interests of confidentiality.)

Background as reported by Social Services

Cameron, aged 10, was referred to the clinic by his social worker. The referral stated that Cameron has had a difficult childhood and was traumatized by a number of events in his early life. He suffered neglect and did not receive consistent care. Cameron had reported being beaten by his birth mother and her various partners. Although Cameron was on the child protection register since he was a baby, he came into care only at the age of 8, when he, along with his two younger siblings, went to live with his paternal aunt and uncle. At that time, Cameron had stated that he did not want to return home to live with his mother, as things were not good when he was there. However, he continued to see his mother and the rest of his siblings on a fortnightly basis.

Only a few months into the placement, his carers reported his behaviour as unmanageable, and despite regular input from his psychiatrist, in the form of carer support, the placement broke down. The carers felt they could no longer meet Cameron's needs along with the other two children in their care. They reported that Cameron was very jealous of his siblings, particularly his younger brother, and he had been aggressive towards him and scared him at night. The placement went into crisis and Cameron had to move out that day and be put into emergency respite for a week, before he moved to the current placement with Mrs & Mr Stewart. Contact with his birth mother had only just been re-established, due to the carers' reluctance for this to happen and concern about the contact impacting on the other siblings. According to his social worker, Cameron has always been the child who was 'demonized' by family members and seen as a problem.

Referral

The referral stated that Cameron was developmentally delayed as a young child, and this was attributed to neglect and trauma and/or genetic factors. His speech was described as immature, for which he received support from speech and occupational

therapy. When Cameron started school, he found it hard to conform and do what was expected in the classroom. His behaviour was quite chaotic and he struggled to make progress. His teachers described him as having a flat demeanour and as being unresponsive to encouragement. He was also described as having a poor retention of work, being easily distractible and socially marginalized. Yet, following assessment by an educational psychologist, it transpired that he was also found to be of average intelligence and therefore no longer meeting the criteria for a mild learning difficulty. He was due to transfer to a mainstream secondary school the following year.

The referral also stated that Cameron had a diagnosis of ADHD and, according to his psychiatrist, a presentation consistent with attachment disorder. He has been and continues to be regularly seen by his psychiatrist to monitor his medication.

Mrs & Mr Stewart found that Cameron presented with some unusual and difficult behaviour. According to them, he struggled with change and needed time to adjust to new experiences and activities. They found him to be emotionally immature and lacking enthusiasm.

First impressions of Cameron

At the time of referral, Cameron was undergoing a comprehensive diagnostic assessment of his various difficulties, as well as attending weekly play therapy in another clinic. For this reason, and also considering his difficulties in managing changes and relationships, I made a decision not to assess Cameron.

Mrs & Mr Stewart

Mrs Stewart arrived alone. In her early 40s, she was tall with long, dark hair and an open face, and she spoke eloquently and clearly. She spoke a lot, and in a confident and optimistic manner, leaving little room for uncertainty. She reminded me a lot of a primary school teacher. In our sessions, her main focus was on education and achievements, at least in our first meetings. Mrs Stewart referred a lot to her own boys, who were aged 20, 14 and 13, describing them as sporty grammar school boys. Only as the sessions went on and I gained some trust, was I allowed to see glimpses of the

less well ordered family dynamics, which were illuminated by Cameron's arrival. The biggest challenge Cameron presented was his lack of emotional warmth and his extreme rigidity, which meant that Mrs Stewart had to devote a lot of one-to-one time to Cameron, and consequently had less time for her own family.

Mr Stewart was in the armed forces and frequently spent time away from home. For the same reason he could not attend our sessions. However, Mrs Stewart made frequent references to her husband, describing him as a proactive father and at times becoming tearful when mentioning his absence.

Chapter4: Research ethics

Research ethics

The principal data used in this study was gathered in the form of audio recordings of interviews that were transcribed and anonymized. Informed consent was obtained prior to collecting the data. This was done both orally, at the initial introductory meeting, and in written form. Separate information sheets were created for the children and for their carers, as well as separate consent forms. (See Appendix 1.) Following the advice of the Office for Research Ethics Committees Northern Ireland (ORECNI), drawings were used to aid the children's comprehension of the process.

The wellbeing of the research participants, both children and carers, and the confidentiality of all that they shared with the researcher/therapist, were of paramount importance throughout the research project. The original recordings were deleted as soon as they were transcribed. For the children's assessment sessions, process notes were taken. The full names of the participants were replaced by numbers and later replaced by pseudonyms for both children and carers. At the initial stage of coding, transcriptions were presented to a senior clinician in weekly clinical supervision. While the children and the carers were attending assessment or parent/carer support sessions, parallel files were kept securely at the clinic and treated like any other patient data. These files consisted of: brief session notes, carers' and social worker's contact details, assessment reports, written correspondence, including signed informed consent sheet, signed confidentiality agreement, and notes from the review feedback meeting with Social Services. These cases were closed and discharged once the sessions were completed.

Although the review meeting was bound by the confidentiality agreement with the carers and the clinic, its purpose was to provide feedback to the relevant social worker and the carers about the findings of the child's assessment, and where applicable recommendations were made. In some cases, the recommendation was for the child to come into treatment. It was made clear at the beginning that should the child or the carers require more support than that provided within the parameters of this research, it would be offered as it would be for any other patient attending the clinic. It was also made explicit, in both written and oral form, that, should the participant (a child or an adult) decide that they no longer wished to take part in the research, they could

withdraw from the research at any point; and they could begin to receive treatment if they so wished.

Ethical approval for this research project and this dissertation was granted by the following organizations:

- Tavistock & Portman NHS Trust in association with the University of East London (UEL);
- The Office for Research Ethics Committees Northern Ireland (ORECNI);
- Belfast Health & Social Care Trust.

Chapter 5: Literature review

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Literature review

Preliminary remarks on the timing and presentation within the thesis of the literature review

Since the present research study has been carried out in accordance with the principles of Grounded Theory (for fuller details, see Chapter 6 below), it is imperative at this point to address the controversial issues of the role and timing of the researcher's review of the existing literature:

- at what point in the research enterprise should the researcher review and reflect on the existing body of (apparently) relevant literature; and
- at what point (or points) in the thesis should the consideration of relevant literature be laid out.

According to Barney Glaser and Anselm Strauss (1967), the founders of Grounded Theory, this new methodology facilitates '*the discovery of theory from data'* (Glaser & Strauss, 1967: 1), implying that in using Grounded Theory the researcher is not focused on testing hypotheses taken from existing theoretical frameworks, but rather is expected to develop new theory that is 'grounded' exclusively in empirical data collected in the field (in the case of this study, in the therapy room). This data, therefore (in this case, the transcripts of the sessions with the children and their carers), should be deliberately privileged above any extant theoretical concepts. Glaser & Strauss take a hard line on this issue: '*An effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study.*' (1967: 37) This approach flies in the face of most other research methodologies, which usually insist that the research should to be carried out within the context of up-to-date knowledge of established findings in the particular field of study. The point of the recommendation by Glaser & Strauss that the researcher should ignore the existing body of relevant literature seems to be that the researcher should approach the collection and analysis of research data with as open a mind as humanly possible with regard to the significance and meaning of that data, so as to maximize the likelihood of theoretical innovation.

Not surprisingly, the founders' extreme stance has generated a lively controversy ever since. A less purist position on this important issue advocates that '*researchers integrate existing literature on the substantive topic into their thinking as the theoretical categories and framework stabilize.*' (Locke, 2001: 122) This approach represents the respectful, yet critical, stance towards extant theories that has been adopted in the present study. I have to agree with J. R. Cutcliffe, who insists that '*no potential researcher is an empty vessel, a person with no history or background.*' (Cutcliffe, 2000: 1480) As Amanda Coffey and Paul Atkinson (1996) quite rightly remark:

> '*The open-mindedness of the researcher should not be mistaken for the empty mindedness of the researcher who is not adequately steeped in the research traditions of a discipline. It is, after all, not very clever to rediscover the wheel, and the student or researcher who is ignorant of the relevant literature is always in danger of doing the equivalent.*' (Coffey & Atkinson, 1996: 157)

Adele Clarke summarizes this attitude to the role of the literature review somewhat facetiously: '*There is actually something ludicrous about pretending to be a theoretical virgin.*' (Clarke, 2005: 13) While there is now a consensus among Grounded Theory researchers that a full literature review is always required, what remains to be clarified is its role and timing in the generation of new theory. Ciarán Dunne has recently summarized the current state of thinking as follows: '*The crux of the matter is not whether a literature review should be conducted – there is consensus that it should – but rather when it should be conducted and how extensive it should be.*' (Dunne, 2011: 113)

Turning to the present research study, since it was clear from the very outset that the study was going to involve looked-after children and the interactions of their foster carers with a psychoanalytic psychotherapist/researcher, it made good sense to begin with a review of the relevant psychoanalytic literature on work with the parents/carers of children in therapy and/or in care, and on the challenges commonly reported by those carers in dealing with the children in their care. It was also assumed from the very beginning that all the children in the research study had been taken into care in the first place because of traumatizing experiences in their early life, and furthermore that the very experience of being wrenched away from their birth family was also inevitably traumatizing, so a review of the voluminous psychoanalytic literature on

trauma was indicated. Furthermore, one of the key psychoanalytic concepts in understanding the enduring impact of trauma is Freud's notion of a '*compulsion to repeat*'. Thus far, this preliminary literature review could be carried out even in advance of the selection of the participants, thereby facilitating the mapping out of what Iain McMenamin has called the '*geography of a subject*' (McMenamin, 2006: 134): identifying key work that has already been done, what issues remain central to the field of enquiry, and the knowledge gaps that still exist. This early literature review was also important in the formulation of the preliminary research questions.

However, in keeping with the core principles of Grounded Theory, it was important not to impose too narrow a theoretical framework on the study from the outset, so that the sessions with the carers could be conducted with a fresh ear and an open mind. This was in the spirit of what Karen Henwood and Nick Pidgeon characterize as '*theoretical agnosticism*', which they argue '*is a better watchword than theoretical ignorance to sum up the ways of using the literature at the early stages of the flow of work in grounded theory*'. (Henwood & Pidgeon, 2006: 350) While it seemed foolish in the extreme to ignore the body of work that had preceded the present study, yet it was important to try to avoid listening to the research material, and then reading and re-reading the data, through any narrow and specific theoretical filter. And then, in the course of gathering the data, and later reflecting on it and analysing it – and only at this point – the significance of the concept of 'psychological-mindedness' emerged as central to the analysis. And it was only at this point in the research, as the theory was beginning to emerge from the analysis of the data, that I carried out an extensive review of the literature on psychological-mindedness and its several sub-categories; and subsequently on the carers' defences, a category that also emerged out of my further analysis of the data.

Finally, the question remained: how should the literature review be presented in the written-up dissertation? It could be argued that the second half of the literature review should be presented in segments interwoven into the chapters on Analysis of the Data and Findings, only as the centrality of psychological-mindedness and its sub-categories emerged from the data analysis: in other words, that the presentation of relevant extant literature should keep pace chronologically with the generation of theory from the analysis of the data. On balance, however, I decided that that would disrupt to an unacceptable degree the flow of presentation of the several stages of the

analysis and findings. As a result, the entire review of the literature relevant to the research project, irrespective of the point in the actual analysis at which its significance emerged, is presented in this chapter.

Parent work – a historical introduction

The first case of child analysis, the case of Little Hans (Freud, 1909), was conducted by Freud through a parent. Although early psychic development has always been at the very core of psychoanalysis, the analytic treatment of children did not start until the 1920s, with the work of Hermione Hug-Hellmuth, Melanie Klein, Anna Freud, and the Bornsteins (A. Freud, 1966). Even allowing for the use of play, this work was conducted according to the same basic principles as the psychoanalysis of adults and involved little support for the child patient's parents. Although, in her actual practice, Melanie Klein had considerable input from parents, and seemed to welcome it, she wrote little about it.

In her (1932) paper on 'The technique of analysis in the latency period', Klein acknowledges both the necessity of involving parents in the analysis of their child and the strict limitations of such involvement:

> '*In order for him [the analyst] to be able to do his work there must be a certain relation of confidence between himself and the child's parents. The child is dependent on them and so they are included in the field of the analysis; yet it is not they who are being analysed and they can therefore only be influenced by ordinary psychological means. The relationship of the parents to their child's analyst entails difficulties of a peculiar kind, since it touches closely upon their own complexes.*' (Klein, 1932: 75)

In her (1936) paper entitled 'Weaning', which deals with both the practical and psychological aspects of this difficult time in the baby-mother twosome, Klein does address mothers directly. She outlines the intricate nature of the development of the infant's attachment, from attachment to the breast to the whole person, which gives rise to both destructive and loving feelings towards the same person (the mother),

which in turn create deep and disturbing conflicts in the baby's mind. This movement involves a progression from a phantastic object-relationship, based on early persecutory fears, to a relationship to the mother as a whole person. According to Klein, even if this process goes well, feelings of guilt arise in the child as it perceives its own destructive feelings as a danger to his or her love object. Klein claims that at this particular stage of development children are unable to control their sadism, as it wells up in response to their frustration. In this paper, Klein is referring to normal child development:

> '*Let us consider what happens when the feelings of guilt and fear of the death of his mother (which is dreaded as a result of his unconscious wishes for her death) are dealt with adequately. These feelings have, I think, far-reaching effects on the child's future mental well-being, his capacity for love and his social development. From them springs* the desire to restore…' (Klein, 1936: 293-4)

However, in clinical work with children who have experienced loss, or even multiple losses of their successive caregivers, this internal turmoil is often at the forefront of the work; and an understanding of these dynamics is essential for successful parent work, since the child's efforts to make reparation can easily be misinterpreted or overlooked.

Jack Novick and Kerry Kelly Novick (2000) suggest that the neglect of parent work has social/historical, theoretical, and political reasons. Novick & Novick draw on Freud's adolescent letters to Silberstein (Boelich, 1990) and on his understanding of the case of Little Hans (Freud, 1909), where the mother is idealized yet stripped of any overt power, including sexual power, and the pre-oedipal mother is denied.

> '*The mother is not seen as having much impact on the child's development except as an object of desire and thus an occasion of rivalry with father. It is the* father's *threat that combines with the boy's developmental desires to produce what Freud termed the Oedipus complex.*' (Novick & Novick, 2000: 55-6)

Novick & Novick also suggest that the major shift in Freud's thinking (Freud, 1897), from an emphasis on external reality, which would include the impact of the parents

on the developing child, to his focus on intrapsychic wishes and desires as the prime determinants of neuroses, also emphasized the endogenous unfolding of psychosexual phases independent of environmental influences.

At the time of the Second World War, many clinics offered parallel work for parents and children. However, this produced another issue, which Anna Freud, in her discussions with Joseph Sandler, summarizes as follows:

> *'There is a point which is not usually taken sufficiently into account by child analysts. With adult patients who have children, analysts see very clearly in analysis what a small part of the parents' personality is really involved with the child, and how great is the part that has nothing to do with the child. In working with the parents of a child in analysis, analysts are addressing themselves primarily to that area in the parents' inner life which is involved with the child. This refers to mothers and to fathers as well. It is quite wrong to think that because the child is so highly involved with the parent, the parent is equally exclusively involved with the child.'* (Sandler et al., 1980: 217)

Donald Winnicott, the first male child psychoanalyst in Great Britain, in his declaration at the Scientific Meeting of the British Psychoanalytical Society in 1940 that '*there is no such thing as an infant*', was insisting that the infant and its maternal carer together form a unit, thus putting parenting at the heart of child development. Winnicott devoted his quest for knowledge and his clinical practice to enhancing our understanding of this unit, including his series of broadcasts entitled *The Ordinary Devoted Mother and Her Baby* (Autumn 1949). To fathers Winnicott ascribes the vital role of protector of the baby-mother unit. His work also included work with evacuated children who had lost their parents during the bombings in Oxfordshire, where he was appointed as a psychiatrist in 1941.

In 1949, John Bowlby wrote one of the first papers on work with families. Although Klein and Bowlby disagreed about the need to see the parents of a child in treatment (Holmes, 1993), the development of attachment theory (cf. the Adult Attachment Interview (Fonagy et al.,1991)) encouraged new psychoanalytic thinking in relation to intrapsychic and interpersonal family dynamics. John Byng-Hall has referred to this new area of development as '*the effect of relationships on relationships*' (Byng-Hall, 1995).

In an influential paper entitled 'Family scripts: a concept which can bridge child psychotherapy and family therapy thinking' (1986), Byng-Hall underlined the need for collaboration between the two disciplines.

As a result of these various influences, parent work has become a common practice amongst child psychotherapists. Initially this parent support was provided by psychiatric social workers, but more recently the practice has developed of child psychotherapists supporting each other in offering psychoanalytically-informed parent work in parallel to the child's psychotherapy. However, with the changes in the ways children are parented – i.e., most mothers are now working outside the home through most of their child's childhood, the number of single mothers has increased dramatically, as has the number of family breakups – various types of parent work are now available. Parents are now able to avail of support from various disciplines, including psychotherapists, social workers, psychologists, counsellors, nurses and other professionals. The parent work takes various forms: including, for example, various parenting programmes, training for foster carers and kinship carers. The emphases of these programmes are on providing information, teaching coping strategies or providing therapeutic input. (Rustin, 1999)

Margaret Rustin (1999) refers to the conceptual framework that distinguishes psychoanalytic parent support from other disciplines, particularly where the unconscious is concerned. Firstly, she writes about the distinction between infantile and adult states of mind, both in relation to the child's development and to parenting capacity. The second distinction she makes is between the maternal and paternal aspects of personality and parental functioning: i.e., between nurturing and limit-setting parental modes. Thirdly, she highlights the significance of the Oedipus complex and its development.

> '*Finally, the experience of shame among parents who need help with their children is a significant clinical problem – their sense of failure and incompetence, and their dread of being despised and humiliated by those felt to be more successful at being grown-up is a severe hindrance in parent work. Linked to this is unconscious envy, with its corrosive impact on relationships which stir up a sense of need.*' (Rustin, 1999: 210)

Martha Harris and Helen Carr (1966) describe a type of brief '*therapeutic consultation*', in which the 'containing' role of the therapist (or indeed other, non-psychoanalytically-trained, professional) is similar to that of the observer in baby observation.

> '*A genuine interest, conveyed without any claim to "magical expertise"*', Harris believes, '*can aid in restoring the parents' own creativity, putting them back in touch with their own "unique knowledge of themselves and their child".*' (Harris & Bick, 2011: 304)

She does acknowledge, however, that '*there are of course many cases where parents and/or child may be too ill to derive any benefit at all from the kind of consultation which I have described.*' (Harris & Bick, 2011: 311)

Even within the strictly psychoanalytic framework, parent support includes a wide spectrum of work, with different emphases depending on the child's developmental stage, family constellations and dynamics, the child's presenting difficulties, and so on. For the purposes of this research, the investigation will explore support provided by a psychoanalytic child psychotherapist to long-term foster carers. Accordingly, the section that follows will consider the issues that commonly arise when a foster carer or a foster carer couple assume the care of a child who has suffered adverse experiences while in the birth parents' care, who has been removed from the birth family and therefore lost their birth mother and/or father, and who almost certainly has subsequently experienced several losses of carers before reaching his or her long-term foster carer(s).

Common challenges facing foster carers

In order to consider the experiences of the foster carers, it is important to give due thought to the issues foster carers frequently face in caring for children who have suffered neglect, abuse and traumatic impingements that have led to them being taken into care. (Boston & Szur (1983), Hunter (2001), Kenrick et al. (2006), Hindle & Shulman (2008)). This section will identify just a few of those common issues and challenges, which surface recurrently in the research data in this study.

- **The child's feeling of not being worthy**

(Mrs Winters, speaking about Tony's view of himself, session 3, paragraph 61)

> *…He said, 'I'm a bad boy' and I said, 'why would you say that, Tony?' I said, 'I don't think you're a bad boy'.*
>
> *'I am a bad boy'. So I says, 'no, you're not a bad boy, love, sometimes you do things that maybe you're not meant to do, but you're not a bad person.'*
>
> *And he said, 'but I don't know how to be good'. Now I find for a wee six-year-old little boy to come out with something like that, it's .... he said, 'I don't know how to be good', and I said, 'well then we'll help you'.*

Children who arrive into foster families come from the experience of turbulent relationships that have resulted in the loss of their whole birth family. Some of them have already experienced multiple placements, and therefore multiple losses, often with little or no preparation. As well as the overriding context of loss, even their long-term placements do not offer permanency. All of this experience makes it very difficult for the child to see him or herself as lovable, or the carers as reliable.

- **Confusion in child/adult roles**

(Mrs Morgan, speaking about Anna's self-reliance, session1, paragraph 137)

'See that's what I found hard at the beginning, too. She was so used to doing everything herself, and when I came in and said she was allowed to do this and she wasn't allowed to do that, she kind of didn't like that, you know. Because then I used to get back, 'but my mummy lets me', I used to always get that back in my face, 'my mummy lets me do that'. And I says, Anna, you're too young to go to the park on your own, you know, it's not safe to go to the park on your own.'

The child with these kinds of experiences often develops attachment patterns that are shaped by neglect and abuse (Hodges & Steele, 2000; Hodges et al, 2003; 2009). Mary Ainsworth (Ainsworth, 1967; Ainsworth Witting, 1969; Ainsworth et al., 1978) writes about an *'insecure avoidant'* attachment pattern that results from the child's experience of parenting that has not been reliably available or responsive and could not be trusted. This leads the child to develop ways of coping that are excessively self-reliant, and the child finds it very hard to rely on grown-ups for emotional support. Sándor Ferenczi (1933) described a child like this as *'a wise baby'*, where the child develops a pseudo-mature part of his or her personality in order to mother itself.

- **Violent outbursts**

(Mrs Patterson, speaking about Kevin's sudden outburst, session 1, paragraph 49)

'… he run to his bedroom and he started to shout "You F*** B***, I'm going to kill myself, you F*** B***, I'm going to kill myself." "No I'm not going to kill myself, I'm going to let the blood drip out of me slowly so you can watch me." I mean, it went on and on and on. And my neighbour is going, "what is wrong with that wee boy?" And I went, "I have no idea." Now, the next morning I said to him, "Kevin, do you know all the things that you said, it doesn't matter." You know? But then when he came in from school that day he sat down and his head was on my knee, you know what I mean, he just lies down when he's watching TV, on my knee.'

Despite the self-reliance associated with the *'insecure avoidant'* attachment pattern, according to Ainsworth the child still has a strategy that aims to maintain the proximity of the adult. According to Mary Main and colleagues (Main & Hesse, 1990; Main &

Solomon, 1990), there are some children who, in order to survive their traumatic early relationships, develop a more worrying attachment pattern, which she called a *'disorganized-disoriented'* attachment strategy. This attachment pattern develops from a child's experience of his or her carers as frightened, frightening, or both; and these children are prone to sudden states of being out of control and violent. They tend to be less able to manage their emotional states, regulate their arousal (Fonagy, 2001) and *'mentalize'* (Fonagy and Target, 1997). However, they may have different attachment patterns for different relationships (Fonagy, 2001), so that siblings, for example, may be perceived and related to differently from the mother.

Bion (1962) used the term *'nameless dread'* to describe the anxiety that an infant may experience if his primitive anxieties are not contained. For many of the children in this research study, such anxieties are aroused easily and therefore frequently. In the carer's experience of the child, these explosive anxieties are likely to come *'out of the blue'*.

- **The child is difficult to settle**

(Mrs Winters, speaking about Tony's difficulties in regulating his affect, session 1, paragraphs 66-69)

> *'… he used to scream, he used to get himself in a state, didn't he? And he used to scream and he could scream for two or three hours solid and whatever we did we couldn't bring him out of it. We don't know why he did it, but he would scream constantly. (…) And no matter how much you tried to coax him round or, you know, trying to get him interested in something, he would just continually scream. It was like something had triggered in his head, that something had either frightened him or …, and, and it took us a couple of years, more than a couple of years, to get him over that, the screaming.... It was, you know, it was very stressful, it was very hard on us...'*

Neurobiological research has demonstrated that a child's exposure to stress and trauma from as early as foetal age is likely to impair the child's development at a

physiological level. The literature on this topic is vast, and a full consideration of the lasting neurobiological impact of trauma, abuse and neglect in infancy lies well beyond the scope of this research study. Just a few indicative references to the literature, which by and large supports and underpins the discoveries of psychoanalysis, will have to suffice.

Daniel Stern (1985) writes about the role of the '*stress hormone*' cortisol in developing hyper-vigilance in the brain, which makes it harder for the child to self-regulate; and as a result these children are more prone to aggressive outbursts. Graham Music (2006) refers to the brain's development being '*experience dependant*' (p. 46); and Perry et al. (1995) write that the 'states' caused by traumatic early experiences can become 'traits', especially when the trauma is severe and frequent. Alan Schore summarizes the lasting effects of traumatizing experiences on the capacity for affect regulation as follows:

> '… *traumatic states in infancy trigger psychobiological alterations that effect state-dependent affect, cognition, and behaviour. But because they are occurring in a critical period of growth of the emotion regulating limbic system, they negatively impact the experience-dependent maturation of the structural systems that regulate affect, thereby inducing characterological styles of coping that act as traits for regulating stress.*' (Schore, 2001: 212)

The parenting of children who have suffered severe trauma is a challenging task: psychoanalytically speaking, it could be said that these children are predominantly stuck in the paranoid-schizoid position with an inner world full of persecutory objects, they tend to overuse defences such as splitting, projection and projective identification, and most of the time they have little or no notion of a good internal object.

Such children's traumatizing early experiences most often generate a wide range of distressing symptoms, such as chronic anxiety, guilt (including survivor's guilt), sleeplessness, depression, flashbacks and nightmares, low self-confidence, a breakdown of trust in the goodness or fairness of others, persecutory phantasies, rage and uncontrollable aggression, and the breakdown of relationships. Commonly thought of as symptoms of Post-Traumatic Stress Disorder (PTSD), sufferers typically feel that their world has collapsed: their life has lost much of its meaning that can never be recaptured, and they can no longer think of the future with any confidence.

There is no doubt that caring for a child who has had very challenging early beginnings can also have many rewarding aspects: for example, children who have suffered serious neglect and traumatic experiences often develop characteristics such as social sensitivity and openness, creativity and resourcefulness, the need to help others, etc.; all of which can make them very likeable and can endear others towards them. But this literature review deliberately focuses on the bleaker, more disturbing features of these children, in order to enable us to understand better the challenges facing those assuming long-term parental care for them.

Trauma

Having briefly reflected on the turbulent states of mind often experienced by foster children who have suffered neglect and abuse, the following section will briefly review the psychoanalytic literature on the phenomenon of trauma: trauma understood as both the distressing, yet more ordinary, life events of an infant and young child that shape its internal world, and the effects of severely traumatizing events in the child's external environment. In this context, some thought will also be given to the compulsion to repeat.

According to The Oxford English Dictionary (1971: 3387), the word 'trauma' applies to both the cause and its effects. The word was originally used (and still is used in medicine and surgery) to refer to a piercing of the skin or damage to tissue as a result of external violence. Freud, however, extended its use to refer to (i) the metaphorical piercing of the protective 'skin' of the mind by a shocking experience, (ii) the psychic wound caused by the violent, piercing event, and (iii) the consequences of the event affecting the whole personality. (Freud, 1920)

- **Trauma and the inner psychic world**

Trauma has been defined in a variety of ways by psychoanalysts. Psychoanalytic definitions differ from those used in general psychiatry, in that trauma is here defined principally by the impact of events or experiences on the individual's inner world (Garland, 2002, *passim*). The general psychoanalytic understanding is that the level of impact of a traumatic event or sequence of events (in later life as well as in childhood) will depend on the inner world of the individual, and specifically their relations with their internal objects: i.e., the figures that inhabit their internal world, especially versions of parental figures, and their unconscious beliefs about them. Many years after Freud's early, ground-breaking discoveries about the lasting impact of trauma, neuropsychologists have now established that '*a baby's emotional environment will influence the neurobiology that is the basis of mind*.' (Balbernie, 2001: 237)

Freud's earliest assumption was that traumatic events are essentially sexual, of a stimulating and abusive kind, taking place in early childhood and forming an underlying traumatic disposition in the form of fixation of libido at one of the key psychosexual stages of development; and therefore we are all subject to this level of trauma, to one degree or another. However, for Freud, this infantile trauma is not the direct cause of neurosis. This outcome requires a later accidental or contingent experience, during or post puberty, to revive the original trauma and produce the neurosis. In other words, for Freud two events are necessary to produce a neurotic condition. As Freud wrote (with Breuer), in his 'Preliminary communication' in advance of the *Studies on Hysteria*: '*Hysterics suffer mainly from reminiscences!*' (Freud, 1893: 7)

- **Trauma and external or environmental events**

Like Freud, Ferenczi (1933) believed that two experiences were necessary to make a trauma pathogenic, since not every trauma has a pathogenic effect. However, Freud famously changed his mind, in the final years of the century, and came to the view that the infantile (sexual) trauma had almost always occurred in the phantasy world of the child, rather than in real life. Ferenczi, on the other hand, continued to regard the

pathogenic infantile trauma as much more often real than imagined, in the actual experience of the child.

It was the carnage and aftermath of the First World War, and the subsequent widespread incidence of the so-called 'war neuroses' (also popularly known as 'shell-shock'), that brought Freud's attention to '*traumatic neuroses'*. In his short but seminal paper '*Beyond the pleasure principle*' (1920), Freud states that with traumatic neuroses, which occur '*after accidents involving a risk to life'*,

> '*the chief weight in their causation seems to rest upon the factor of surprise, of fright; … the name we give to the state a person gets into when he has run into danger without being prepared for it.'* (Freud, 1920: 12)

This is one of the many instances where Freud described and conceptualized phenomena that later came to be confirmed by developmental neurobiology. Alan Schore, for example, has pointed to the common response to trauma by infants in both their sympathetic and parasympathetic nervous systems: 'Under stress a developmentally immature orbitofrontal regulatory system would give way to a coupled nonreciprocal mode of autonomic control … and the simultaneous activation of hyperexcitation and hyper-inhibition results in the "freeze response".' (Schore, 2001: 230)

Freud here conceptualizes the mind as a '*psychic apparatus'* that has developed a '*protective shield'*, which enables it to be highly selective in its reception of stimuli from the external environment via the senses. This is in line with the workings of '*the principle of constancy'*:

> '… *the mental apparatus endeavours to keep the quantity of excitation present in it as low as possible or at least to keep it constant'* (*ibid*: 9). In fact, '*protection against stimuli is an almost more important function for the living organism than reception of stimuli'* (*ibid*: 27).

[Incidentally, in keeping with this model of the mind and the limited stimulation it can successfully manage, it is now widely accepted that sensory over-stimulation of young children will typically bring about not accelerated learning, as had previously been widely assumed, but rather bewilderment, and it is a significant barrier to successful development.] Freud describes as 'traumatic' any excitations from outside that are

powerful enough to break through the protective shield and overwhelm the fragile mind; and he concludes that a traumatic neurosis is '*a consequence of an extensive breach being made in the protective shield against stimuli.*' (*ibid*: 31)

The shifts in meaning and usage of the concept of trauma continued after Freud. Fairbairn suggested that the danger of 'trauma' is ever-present in the life of every child:

> '*The greatest need of a child is to obtain conclusive assurance (a) that he is genuinely loved as a person by his parents, and (b) that his parents genuinely accept his love. … Frustration of this desire to be loved as a person and to have love accepted is the greatest trauma a child can experience.*' (Fairbairn, 1952: 39-40)

The enduring effects of the persistent frustration of this basic desire are evocatively captured by Masud Khan's (1963) description of 'cumulative trauma'.

Anna Freud (1967) defined as 'traumatic' an external event (or series of events) that overwhelms the patient's defences. More specifically, according to this view, trauma overwhelms the organizing, regulating, and integrating functions of the ego (Greenacre, 1967). In the same paper, Anna Freud refers to the danger of the concept of 'trauma' being emptied of meaning through overuse and over-extension. She made a distinction between the two different categories of psychopathology: one caused by trauma and the other due to '*pathogenic influences in general*' (p. 236). However, she did not elaborate on the differences or clarify the boundary between them.

- **Variations on psychic trauma**

In contemporary psychoanalytic thinking, this dichotomy of internal versus external sources of trauma is viewed less rigidly. Clinicians more than ever appreciate that the internal world of the child is largely shaped by and dependent upon external events and circumstances; and this is especially pertinent to the emotional development of looked-after children. (See Baranger et al., 1983; Bion, 1970; Ferro, 2002 & 2005; Howard & Levin, 2014.)

'*From this perspective, what matters is not where the stimulus (excitation, drive derivative, bodily sensation, fantasy, affect, tragic event, etc.) originates—inside or outside—but whether, how and to what extent it is processed by the mind and then how it is or is not used in a creative way in relation to the other.*' (Howard & Levin, 2014: 217)

There are many varied and significant contributions made by various psychoanalytic authors to our thinking about the impact of trauma (however understood) on an individual and on their object relations: for example, shock trauma and strain trauma (Kris, 1956), massive psychic trauma (Furst, 1967), cumulative trauma (Khan, 1963), micro-trauma, screen trauma (Sandler, 1967), and so forth. (See also Abraham, 1907; Greenacre, 1953; Winnicott, 1958; Balint, 1969, and others.)

Kris points out that the complexity of factors that post-date any one traumatic experience will always play a part in how experience emerges in the here and now, as well as in how we interpret it, since inevitably childhood trauma becomes fused with its aftermath, intertwined with other developmental conflicts, and revived during subsequent developmental phases, not least in adolescence (Kris, 1956).

It is not surprising, therefore, that a single psychoanalytic theory of trauma becomes impossible to define, as it encompasses such a wide range of variables that must be considered, such as individual qualities of the subject (age, parental psychopathology, ethnicity, gender, social influences), type of traumatic experience (childhood sexual abuse, early parental loss, neglect or maternal mis-attunement, war, genocide, torture, rape, etc.), its severity, and so on. In addition, the experience of trauma and its aftermath has been proven to be highly subjective from person to person: as shown, for example, in the studies of children of survivors of the Holocaust (Levine, 1982).

Perhaps the description that comes closest to encompassing these wide variations of human experience is the one offered by Freud himself, in his paper on 'Instincts, symptoms and anxiety' (1926), where he defines '*a traumatic situation'* in terms of the original and prolonged '*situation of helplessness'*, total vulnerability and dependence in which every person found themselves in early childhood (Freud, 1926: 166), and to which they psychically return in the aftermath of the severe trauma, thereby abandoning all rational assessment of their current situation.

The compulsion to repeat

> '*We see that children repeat in their play everything that has made a great impression on them in actual life, that they thereby abreact the strength of the impression and so to speak make themselves masters of the situation.*' (Freud, 1920: 14)

Many foster carers will recognize this tendency in a child's play, but without some understanding of how these processes relate to infantile and childhood trauma, they will often struggle to make sense of the child's at times bizarre, challenging, and frequently self-sabotaging behaviours, especially in what is clearly a good and caring (and new) family situation. This section will endeavour to review some of the main psychoanalytic views in relation to what Freud dubbed '*the compulsion to repeat*'.

Repetition has been a cornerstone of psychoanalytic understanding almost from its beginnings. It was alluded to by Freud in the case studies of Dora (1905) and Little Hans (1909). In 'Remembering, repeating, and working-through' (1914), Freud observed that patients tended to repeat their neurotic conflicts during analysis rather than remember those conflicts' traumatic origins: repeating, Freud concluded, is the neurotic's way of remembering. The concept of a '*compulsion to repeat*' was then introduced by Freud in his seminal 1920 paper '*Beyond the pleasure principle*'.

Karl Abraham, in his 1907 paper 'The experience of sexual traumas as a form of sexual activity', had already described the phenomenon whereby certain children who have experienced sexual trauma are predisposed to repeated sexual traumas in later life, what Abraham termed '*a traumatophilic diathesis*'. Abraham also noted that this phenomenon is not limited to sexual traumas (Abraham, 1907: 57).

Sándor Ferenczi insisted that this compulsive repetition was caused by severe early trauma in the life of the child. He proposed the theory that, if traumatic assault has taken place at an early developmental stage, which he described as '*a purely mimetic period*' (Ferenczi, 1932: 148), and if the trauma has been of such severity that it has overwhelmed the ego's capacity to tolerate displeasure, the ego will respond by a mimetic (or imitative) reproduction of the aggressor's desires, leaving an imprint that

Ferenczi called an '*alien transplant'*, which closely resembles Freud's concept of a *'death instinct'* (Avello, 1998: 229).

Freud, Abraham, Ferenczi and others were struggling to understand the powerful repetitions observed during psychoanalytic sessions, as well as their accompanying resistances (Strachey, 1955: 3-4). In relation to more ordinary trauma, such as the normal separating from mother, Freud saw the repetitive nature of a child's play as an attempt by the child to assert a symbolic revenge on those who had inflicted the original trauma, all in a desperate attempt to master the traumatic experience. (Freud, 1920)

However, in Freud's view the excitation produced by severe trauma can be neither discharged nor psychologically worked through, and as a result it is experienced by the individual as threatening to his or her cohesion and therefore cannot be accessed in the usual (cognitive) way. He suggests that, in attempting to understand the resulting psychic state, '*a purely descriptive method of expression*' must be replaced by '*a systematic or dynamic one*'. Accordingly, Freud states that, while the resistance on the part of the analysed person proceeds from his ego, the '*repetition-compulsion'* must be ascribed to '*the repressed element in the unconscious.*' And that '*repressed element*' that fuels the compulsion to repeat cannot find expression, and emerge from the unconscious, until repression is 'loosened' in the course of the treatment. (Freud, 1920: 19)

Child psychotherapists working with severely traumatized children, as well as those children's foster carers, often find themselves in a distressing situation with a child that seems to be repeated by the child over and over again, and they often feel utterly helpless in their attempts to reason with the child. Freud understood this phenomenon as follows: *'The repressed memory-traces of his primitive experience are not present in a "bound" form, are indeed, in a sense, not capable of the secondary process.'* (Freud, 1920: 43-44) In other words, the repressed material is not capable of being symbolized in words and expressed in discourse. Freud goes on to describe how, with his binding functions overwhelmed, the individual can only repeat the traumatic situation in a compulsive fashion, as a way of trying to bind the experience. However, as he had already made clear in his 'Little Hans' paper, *'a thing which has not been*

understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been solved and the spell has been broken.' (Freud, 1909: 122)

Freud also observed the perplexing fact that the repeated events seemed to violate his cherished pleasure principle: the experiences being repeated tended to be painful and unsatisfying past events and relationships that had never led to pleasure in the first place and '*included no possibility of pleasure.'* (Freud, 1920: 20) He came to the conclusion that the compulsion to repeat is rooted in something *'more primitive, more elementary, more instinctual than the pleasure principle which it overrides.'* (Freud, 1920: 23) He even described the driven quality of the compulsion to repeat as '*demonic*' (Freud, 1920: 21) and attributed it to what he called a '*death instinct*'.

Paul Russell, in his paper entitled 'Trauma, repetition, and affect' (2006), captures the power of this phenomenon beautifully:

> '*It can be a very simple affair, or extraordinarily complex. It can be of such complexity and power that one has the impression that it is the act of an intelligence that is more than a match for one's own. It can at times operate like a doom, a nemesis, a curse. The same thing will happen, again and again, despite one's best efforts at avoidance, prevention, or control. In fact, it gets its name precisely on this account; that despite the apparent wish to avoid the pain, the cost, the injury of the repetition, one finds oneself repeating nonetheless, as if drawn to some fatal flame, as if governed by some malignant attraction which one does not know and cannot comprehend or control. It has, in other words, all of the external earmarks of a volitional act, and yet the person is unaware of wishing any such thing. In fact, quite the contrary; he or she would wish to avoid it.'* (Russell, 2006: 24)

Post-Freudian views of the compulsion to repeat reach well beyond the scope of Freud's work, with the majority of analysts oriented to drive theory and ego psychology maintaining that it is unnecessary to posit an additional death instinct to account for the repetition of painful or traumatic events. Other authors have critiqued the concept of the compulsion to repeat in some detail (Kriegman & Slavin, 1989; Inderbitzin & Levy, 1998; Lazar & Erlich, 1999).

Several authors have maintained a distinction between (i) a more primitive, pre-verbal form of repetition that relates primarily to the *id,* accompanied by more primitive ego defences and characterized as primitive, infantile, stereotyped, and unreflective; and (ii) repetition that relates to the more developed *ego*. The former is oriented at psychic survival and is unlikely to lead to either adaptation or mastery. The latter reflects more flexible, sophisticated, and adaptive functioning, and is characterized by repetition as a belated attempt at mastery. (Cf. Klein, 1976; Gedo, 1979; Kirman, 1996; Inderbitzin and Levy, 1998; Wilson and Malatesta (1989).)

When thinking about looked-after children, the very early and even pre-birth experiences of children in care often have a particularly damaging quality that is more significant and more enduring than any ordinary impingement. The patterns created by traumatic affective experiences in the pre-verbal stage of development, or primal repetitions, are exceptionally difficult to put into words, as they will most likely have their roots in experiences that were not only pre-verbal, but also 'pre-imagistic'. (Wilson & Malatesta, 1989: 296) This knowledge, such as it is, is non-representational and therefore less open to analysis; and repetitions of early traumatic experience potentially pose a fundamental threat to treatment by generating what is sometimes characterized as '*a negative therapeutic reaction'*.

With the exception of Melanie Klein and later Kleinian theorists, Freud's concept of a death instinct or death drive has rarely been adopted by object relations theorists. Instead, the focus of the latter has been on the internalized and repeated early relationships, rather than early drive experiences and conflicts. Some have broadened Klein's concept of projective identification (Klein, 1952) as a means of thinking about compulsive repetitions. Otto Kernberg (1987), Joseph Sandler (1987) and others have described the rationale behind the mechanisms of projective identification either as dissociating from threatening or unacceptable parts of the self or as separation from unbearable experiences in an attempt to control them. (Kernberg, 1987: 100) At the same time, Sandler claims that '*projective identification is more a descriptive than an explanatory concept.'* (Sandler, 1987: 26)

Ronald Fairbairn (1952) emphasized external relationships over internal, insisting that libido is object-seeking rather than pleasure-seeking. This principle implied that there

is no 'pleasure principle' (in Freud's sense) to be violated; and therefore the postulation of either a death instinct or a primal 'compulsion to repeat' is '*superfluous*' (Fairbairn, 1952: 78). Although both Fairbairn and Klein understood that the child needs to internalize the bad objects in an attempt to control them, Fairbairn thought that a more important reason for the child to internalize the bad objects is '*because he needs them*': '*if a child's parents are bad objects, he cannot reject them, even if they do not force themselves on him; for he cannot do without them.*' (Fairbairn, 1952: 67) Furthermore, the more such need is created through neglect and negative actions, the more likely this need, which has been pushed into the unconscious by the force of repression, will follow the child into adulthood. Fairbairn, therefore, has little difficulty explaining how bad objects are internalized and re-experienced (Celani, 1999). In Fairbairn's view, the most difficult task of the therapist is to help the patient to '*get away from these bad objects.*' (Fairbairn, 1952: 78)

Attachment and individuation theorists generally accept Fairbairn's idea that repetition is object-seeking, rather than being generated by innate aggressive or pleasure-seeking instincts or drives. However, Shapiro (1985) sees self-destructive repetition as one component of a tendency to repeat all early relationships, rather than just the negative ones. He emphasizes the need for a growing child to balance the dual needs of attachment and autonomy. In his view, impingements on the creation of this balance result in the development of patterns of relationships that are created to control overwhelming feelings of anxiety and loneliness, and to '*reunite with parental figures.*' (Shapiro, 1985: 302) As a result, invitations by the therapist to abandon these patterns can provoke terror and a '*pull to reconnect with early figures*' (Shapiro, 1985: 307), giving the compulsion to repeat its tenacious, difficult-to-treat character.

Following this train of thought, it becomes evident that the phenomenon of transference is by no means unique to the analytic setting, nor is it to be resolved in analysis. Instead, transference represents a '*microcosm*' that stands for the patient's '*whole psychological life.*' (Stolorow et al., 1987: 36)

This ubiquitous transference must be taken into account when thinking about the dynamics taking place between a child in care and his or her foster carers; and to be more precise, a double transference, one of the child towards the foster carer and the other of the foster carer towards the child. '*Each partner, at any given moment, has a*

role for the other, and negotiates with the other in order to get him or her to respond in a particular way.' (Sandler & Sandler, 1978: 286) In other words, as children and adults interact with each other, each party makes an active effort to protect themselves and to satisfy their own wishes through repeating learned patterns of relationships. Anne-Marie & Joseph Sandler (1978) also write:

> *'The urge to re-experience important subjective aspects of object relationships from the first years of life constantly recurs … particularly when feelings of security and safety are threatened, as they continually are.'* (Sandler & Sandler, 1978: 287)

 According to this view, the child does not simply internalize the behaviour of early objects, but he or she internalizes the experience of a dialectical relationship between self and object, and the quality of this experience will depend on the *'particular individual capacities'* of both parents and child. (Sandler & Sandler, 1978: 292)

Having considered these various theoretical perspectives on the compulsion to repeat, the following section will give some thought to the difficulties faced when encountering the repetitions caused by severe early trauma. In the literature, these difficulties are usually considered in the context of the therapeutic relationship between the therapist/analyst and the patient, but, considering the aims of this research, it is worth bearing in mind that foster carers, in their attempts to parent the traumatized child, are likely to encounter similar dilemmas and challenges as those faced by a clinician.

Psychological-mindedness

In this study, the term 'psychological-mindedness' will be used in a narrow sense: i.e., to assess the foster carers' responses to the child, and to themselves in relation to the child, in a particular stressful situation. This study does not seek to assess the carers' overall psychological-mindedness, but aims more precisely to track the fluctuations in the carers' capacity to parent a traumatized child and learn about the role of defences, especially when encountering manifestations of the child's compulsion to repeat painful earlier experiences. Therefore, to help to clarify the term 'psychological-mindedness' as it is applied in this study, the following section will focus on only a few aspects rather than attempt to give a full overview of the concept.

The early sightings of ideas about psychological-mindedness can be found in Freud's experiments with end-setting, Sándor Ferenczi's (1926) *'active technique'*, Franz Alexander and Thomas French's (1946) *'corrective emotional experience'*, and Kurt Eissler's (1953) *'parameters'*: they all pointed to the fact that patients vary in their responses to psychoanalytic treatment and therefore need various adaptations of technique. Also, when thinking about the patient's suitability for psychoanalytic treatment, certain theories about ego functioning became more relevant, such as Freud's (1923) structural theory, Anna Freud's (1936) analysis of the defensive function of the ego, and Heinz Hartmann's (1939) autonomous ego functions. All of these theories, each in its own way, considered the various factors influencing the patient's psychological-mindedness.

Stephen Appelbaum (1973) offers a useful definition of psychological-mindedness as follows

> :'... *a person's ability to see relationships among thoughts, feelings, and actions, with the goal of learning the meanings and causes of his experiences and behaviour.*' (Appelbaum, 1973: 36)

However, given that the present study crucially considers the carers' capacity for insight into the behaviour of the children in their care, Hope Conte (1996) helpfully extends the concept of psychological-mindedness beyond simple self-focus, pointing out that it also involves '... *both self-understanding and an interest in the motivation and behaviour of others.'* (1996: 251)

The concept of psychological-mindedness will be applied in this study in a particular way. This particular application of the concept emerged from the research data in the course of the researcher's application of Grounded Theory (as will be demonstrated in the later chapters on data analysis and findings). For the purposes of this study, we shall consider the carers' use of psychological-mindedness not only with respect to themselves and their own experiences, but also with respect to another, in this case a foster child. This will include five components.

1) The carer's degree of interest in the way the child's mind works, including their capacity for concern about the child, interest in the self in relation to the child, including insight (as a product of psychological-mindedness) and expressions of empathy.

2) The extent of the carer's focus on the internal world of the child in contrast to the child's external world, and the degree of the carer's curiosity about the complexity, variety, volatility, and richness of content of the child's presentation. Stone (1967: 42) writes about the '*capacity to think abstractly or concretely'.*

3) The carer's tolerance of affect: i.e., their ability to allow affects their rightful place, their tolerance of frustration and tolerance of delay, their ability to experience affects and to integrate feelings with insights, their confidence in their capacity to control and modulate affects, in both themselves and the child.

4) The carer's awareness of the child's capacities and limitations, as well as the child's ways of coping.

5) The carer's awareness of the links between the underlying causes of the child's experience and the child's present states of mind.

The reliable presence of psychological-mindedness in the carer will be considered an essential building block of 'good enough' parenting. However, as we shall see, under pressure of the child's distress and traumatic communication, and the carer's own affective responses to it, the exchange between them may well be experienced by the carer as (re-)traumatizing and can trigger defensively unthinking responses, thereby narrowing the carer's cognitive or emotional awareness, or both. Caroline Garland (1998) describes the impact of trauma as follows:

> *'However well any individual feels he is normally able to take care of what he feels to be his own well-being, some events will overwhelm that capacity, will knock out ordinary functioning and throw the individual into extreme disarray.'* (Garland, 1998: 9)

When the carer's own trauma is thus triggered, the reach of psychological-mindedness becomes extended to encompass the task of protecting the child from what Selma Fraiberg and her colleagues have studied as '*transgeneration behavior*' (Fraiberg, Adelson & Shapiro, 1985). They considered the impact on parents and their children of 'ghosts in the nursery': i.e., when the ghosts of the parental past are unconsciously inflicted upon the child. The key here is the degree of parents' repression of the painful experiences of their childhood, such as anxiety, grief, shame or self-abasement. If those experiences had never been fully repressed, or if repressed memories of them had been released and dealt with through psychotherapy, the parents in the Fraiberg study were able to say, '*I would never want that to happen to my child':*

> '*For these parents, the pain and suffering have not undergone total repression. In remembering, they are saved from the blind repetition of that morbid past. Through remembering they identify with an injured child (the childhood self), while the parent who does not remember may find himself in an unconscious alliance and identification with the fearsome figures of that past. In this way, the parental past is inflicted upon the child.*' (Fraiberg et al., 1985: 420)

On the other hand, it is just as important to consider the factors that might facilitate an increase in an individual's psychological-mindedness when under pressure, in this case the pressure of a severely distressed child. One of the essential factors in such a development is the concept of 'holding'. However, 'holding' is one of those concepts that has been almost taken for granted throughout the history of psychoanalysis, but has been used in psychoanalytic discourse in a wide variety of ways. In her paper '*On interpretation and holding',* Anne-Marie Sandler (1985) writes:

> '*I realised that most people, including myself, assume that they possess a relatively clear and simple idea of what is meant by "holding". But when one does more than scratch the surface, it becomes clear that "holding" belongs to that class of concepts which are "elastic", which change their meaning according to the context in which they are employed.*' (Sandler, A., 1985: 3)

Since the early days of Freud's practice, a sense of being held has been provided through the analytic situation, the consistency and predictability of the setting. The

actual term '*holding environment*' was first introduced by Donald Winnicott in 1965, in his paper 'The maturational processes and the facilitating environment':

> '*The term derives from the maternal function of holding the infant, but taken as a metaphor, it has a much broader application, and extends beyond the infantile period — where the holding is literal and not metaphorical — to the broader caretaking function of the parent.*' (Sandler, A., 1985: 3)

Winnicott's idea of 'holding' is closely linked to Ferenczi's (1926) ideas on '*active technique*', ideas that were carried forward in England by the writings and technique of Ferenczi's follower Michael Balint (1968). The theories of Heinz Kohut (1971) were also based on the notion of environmental failure in early childhood, and he emphasized the holding function of empathy rather than interpretation of the internal conflict.

A slightly different take on this idea was offered by Wilfred Bion (1962), when he described the concept of '*container-contained*'. Bion's theory claimed that knowledge of the psychological precedes knowledge of the physical world. In his view, the infant's use of projective identification is the first mode of communication, which is (or is not) in turn internalized by a mother (the container), who then bears the emotional impact of these projections and makes sense of what the infant is transmitting via projective identification (the contained). Bion called this maternal engagement '*reverie*' or '*alpha-function*'.

He went on to suggest that the development of thought depends on this process, using the concept of 'thinking' in a broader sense, which is very similar to the notion of 'psychological-mindedness' as used in this study. O'Shaughnessy (1981) clarifies this as follows:

> '*His concern is with thinking as a human link — the endeavour to understand, comprehend the reality of, get insight into the nature of, etc., oneself or another. Thinking is an emotional experience of trying to know oneself or someone else. Bion designates this fundamental type of thinking — thinking in the sense of trying to know — by the symbol K. If xKy, then "x is in the state of getting to know y and y is in a state of getting to be known by x".*' (O'Shaughnessy, 1981: 181)

The present study aims to explore the ways in which child psychoanalytic psychotherapists can facilitate foster carers' psychological-mindedness towards the children in their care by providing emotional holding for their anxieties. However, in order to assess the impact psychoanalytically-informed parent support can have on carers, it is necessary to clarify some sub-categories within which psychological-mindedness will be considered, such as empathy and other dimensions of psychological-mindedness.

Psychological-mindedness and empathy

In his paper 'On beginning the treatment', Freud emphasizes the importance of empathy [*Einfühlungsvermögen:* literally, the capacity to feel into] in establishing what we now understand as the therapeutic alliance that is a prerequisite for any psychoanalytic interpretation.

> *'It is not easy to feel one's way [einzufühlen] into primitive modes of thinking. We misunderstand primitive men just as easily as we do children, and we are always apt to interpret their actions and feelings according to our own mental constellations.'* (Freud, 1913: 103)

However, one of the curious aspects of Freud's conception of empathy, in which he emphasizes the use of empathy in the understanding of the alien self in another person, is his stress on its intellectual features, and his relative neglect of its affective features (cf. Freud, 1912: 115-116).

Melanie Klein used the term projective identification in several ways as her thinking evolved, as a psychological mechanism underlying several crucial functions, from expulsion to communication. In her paper *'The emotional life of the infant'* (1952), she is clear that projective identification plays a vital role in the interaction between internal and external worlds, in the individual's attempt to make emotional contact with others. (Klein, 1952: 142-3) Robert Hinshelwood summarizes this aspect of projective identification as follows:

'*At the very furthest point on the benign end of the scale is a form of projective identification underlying empathy, or "putting oneself in another's shoes" ... In this case the violence of the primitive forms has been so attenuated that it has been brought under the control of impulses of love and concern.*' (Hinshelwood, 1994: 133).

Wilfred Bion (1959, 1962), developing Klein's idea of projective identification, expands on the communicative aspect of the mechanism in his notion of '*container*' and '*contained*', where the recipient of the projection (typically the mother) acts as a container of overwhelming feelings: in other words, empathizes with the child's distress.

'*I shall abstract for use as a model the idea of a container into which an object is projected and the object that can be projected into the container: the latter I shall designate by the term contained.*' (Bion, 1962: 90)

Christine Olden (1953), while acknowledging that '*the adult's capacity to empathize with children is rarer than the capacity to empathize with other adults*', highlights an aspect of the concept of empathy that seems particularly relevant to the present study:

'*Empathy may be described as a feeling that emerges spontaneously in social contact, that enables the subject instantaneously to sense the object's apparent emotions of shyness, hate, haughtiness, happiness, etc. But empathy goes further. It has the capacity ad libitum to trespass the object's screens of behaviour, behind which the real feelings may hide.*' (Olden, 1953: 115).

Dan Buie (1981) offers a useful summary of the various ways in which the concept of empathy has been understood by American psychoanalytic writers. According to Buie, the definition of empathy includes several elements:

'*(1) Empathy involves relating between two persons (Beres, 1968); (Greenson, 1960); (Leavy, 1973); (Schafer, 1959, 1968), (2) and in the process an awareness of separateness between self and object is maintained (Beres, 1968); (Beres & Arlow, 1974); (Fliess, 1942); (Greenson, 1960). (3) It is,*

however, largely an intrapsychic experience (Bachrach, 1976); (Furer, 1967); (Greenson, 1960); (Leavy, 1973). (4) It is a capacity (Bachrach, 1976); (Easser, 1974); (Fliess, 1942); (Furer, 1967) or even a basic human endowment (Kohut, 1977), which (5) involves a form of knowing, comprehending, or perceiving what another person is experiencing within (Bachrach, 1976); (Easser, 1974); (Fliess, 1942); (Furer, 1967); (Kohut, 1959, 1971); (Olden, 1953); (Schafer, 1959). (6) It is an experience of momentary, or transient nature (Bachrach, 1976); (Beres, 1968); (Greenson, 1960). To state this more concisely, one could say that empathy occurs in an interpersonal setting between persons who remain aware of their separateness, yet in essence it is an intrapsychic phenomenon based in a human capacity to know another person's inner experience from moment to moment.' (Buie, 1981: 281)

In this study, the quality of the carers' psychological-mindedness in relation to the foster child will be analysed and evaluated by considering the nature of the carer's statements in relation to the child: the child's desires, preferences, behaviour, moods, qualities, and so on. We shall also be considering and evaluating carers' references to themselves in relation to the child, focusing on statements that indicate empathy, insight, awareness, or lack of the above. Other indicators of psychological-mindedness, in relation to the child's bodily state, affect, defences and narrative, will also be considered.

Other dimensions of psychological-mindedness

For the purposes of this study, the foster carers' psychological-mindedness (or capacity for 'holding' or 'containment') will be considered with respect to their responses to the child's bodily states, affects, defences and narrative. These categories are particularly relevant as all of the participant foster children have suffered severe trauma in their pre-verbal early life, and therefore their carer's understanding of and attunement to the child's non-verbal communications assumes particular importance. Daniel Stern et al. (1983) write:

'The distinction between cognitive and affective knowledge may have little substance until a language-based semantic system emerges.' (Stern et al., 1983: 14)

Based on our understanding of the compulsion to repeat, we could extend Stern's idea to memory: in other words, it is probable that the child's memory of the early trauma will often (in some cases, always) be held and expressed by non-verbal means, such as bodily states or actions, or affect. This makes it crucial for the psychotherapist providing support to a foster carer to be aware of the carer's ability or willingness to read the child's behaviour with reference to the likely internal states, more or less accessible or inaccessible to cognitive reasoning, which might be governing it.

- **Psychological-mindedness in relation to the child's bodily states**

From the observation of infants, a lot has been learned about the ways in which small babies and children make use of their bodies to communicate their feelings: their needs and frustrations, their distress, their moods, etc. Since the very beginning, the psychoanalytic literature has made fundamental links between psyche and soma: from Freud's (1923) insistence that '*the ego is first and foremost a bodily ego*' (p. 26), through Wilfred Bion's (1962) idea of a container of affects, to Esther Bick's (1968) '*second skin*' defences, and others (e.g., Anzieu, 1989, 1990; Stern, 1985; Pollak, 2009). Franz Alexander summarizes the intimate connection between the body and emotional states:

'*Corresponding to every emotional situation there is a specific syndrome of physical changes, psychosomatic responses, such as laughter, weeping, blushing, changes in the heart rate, respiration, etc.*' (Alexander, 1949: 39)

Joan Schachter, in considering the baby's dependence on the parents' emotional attitude towards their baby, focuses on the development of affects and affect-regulation, and how affects that cannot be contained by the care-giver are likely to find expression through the child's body:

'*If affects cannot be contained within the mind, initially the mother's and subsequently the baby's, then they may have to be contained within the body, where they cannot be transformed into fantasy, food for thought and communication. The integration of mind and body is thus impeded and distorted, with serious consequences for the individual's capacity for separateness, autonomy and relating in satisfying ways to others.*' (Schachter, 1997: 213)

The intimate connection between psyche and soma that is detailed by Joyce McDougall (1989) will apply to the foster carers every bit as much as it applies to the traumatized children in their care:

'*Those who habitually use action as a defense against mental pain (when thought and the recognition of feeling would be more appropriate) run the risk of increasing their psychosomatic vulnerability. An affect cannot be conceived as a purely mental or purely psychological event. Emotion is essentially psychosomatic.*' (McDougall, 1989: 95)

Esther Bick (1968) considers the containing function of the mother in terms of 'the primal function' of her skin and the skin of her baby:

'*in its most primitive form the parts of the personality are felt to have no binding force amongst themselves and must therefore be held together in a way that is experienced by them passively, by the skin functioning as a boundary.*'(Bick, 1968: 484)

In this primary un-integrated state, the infant seeks out an object – perhaps a voice, or a smell – that can be experienced as holding the parts of the personality together: '*The optimal object is the nipple in the mouth, together with the holding and talking and familiar smelling mother. ... This containing object is experienced concretely as a skin.*' (p. 484) When the integrating object is not successfully introjected by the infant, whether due to defects in the mothering function or because of phantasy attacks on it by the infant,

'*disturbance in the primal skin function can lead to a development of a "second-skin" formation through which dependence on the object is replaced by a pseudo-independence, by the inappropriate use of certain mental functions, or perhaps innate talents, for the purpose of creating a substitute for this skin container function*.' (p. 484) Cf. Ferenczi's depiction of 'the wise baby'. (Ferenczi, 1933)

As Martha Harris summarizes this phenomenon:

'*reliance and trust in an internal sustaining object is replaced by brittle independence of a muscular kind, some active utilization of the infant's sensory and mental equipment to hold himself together – a state in which the ordinary processes of introjections and projection are not fulfilling their function.*' (Harris, 1975: 36)

Prominent among the outworkings of disturbance of the primal skin function is the child's use of the body for communication:

'*In all patients with disturbed first-skin formation, severe disturbance of the feeding period is ... not always observed by the parents. This faulty skin-formation produces a general fragility in later integration and organizations. It manifests itself in states of unintegration ... of body, posture, motility, and corresponding functions of mind, particularly communication. The "second skin" phenomenon which replaces first skin integration, manifests itself as either partial or total type of muscular shell or a corresponding verbal muscularity*.' (Bick, 1968: 485-6)

Donald Meltzer (1975) uses Bick's insights to illuminate his study of what he calls the '*two-dimensionality*' and '*shallowness*' that follow from failure to introject a primary object who is able to contain and provide a basis for the integration of the personality. (Meltzer, 1975: 235) Drawing on all this material, Martha Harris has pointed out that it '*seems likely that areas and states of non-containment, of two-dimensionality and mindlessness exist in the development of every infant and are therefore in us all.*' (Harris, 1975: 36) This fact has obvious implications, in the context of this research

study, for the relative 'mindlessness' that sometimes incapacitates the carers in the face of the distressing behaviour of the children in their care, so that they find themselves unable to discern any psychological meaning underlying the 'muscular' physical activity of the child.

The use of their body by looked-after children – in the common forms, for example, of hyperactivity, or violence against animals or other children – is a significant means of communicating their internal feeling states. However, this communication is often misunderstood by their carers and met with behavioural management, without seeking any deeper understanding of its underlying meaning. Therefore, in this research study, the carers' comments about the child's bodily states – for example, tense, energetic, vacant, etc. – are taken as a significant indicator of the carer's degree of psychological-mindedness.

- **Psychological-mindedness in relation to the child's affects**

Meins and Fernyhough (2010) developed their 'Mind-mindedness coding manual' to assess parent-infant interactions. The focus of this work is on the caregiver's ability to treat the young child as an individual person with a mind, rather than merely an entity with needs that must be satisfied. This approach developed out of a rethinking of Ainsworth, Bell, and Stayton's (1971) concept of maternal sensitivity. In a similar way, the present study aims to learn more about the ways in which the carer-child minds are linked through the interplay of subjective states. Brazelton et al. (1974) and Stern (1985) emphasize the mother's role in the containing of bad and good experiences in the infant-mother communication. Travarthen and Aitken (2001) write about the need to regulate not only the child's negative states, but the level of excitement in general. For example, it is often reported by foster parents how special occasions such as Christmas can be experienced by traumatized children as overwhelming. In assessing the carer's psychological-mindedness in relation to the child's affective communications, the present study will be assessing the carers' comments about the child's feelings: fed up, shy, happy, sad, scared, afraid, joyful, grumpy, stressed, in a good or bad mood, being difficult, worried, anxious, confused, excited, bad tempered, not being their usual self, etc. The analysis will also note if there is a notable absence of naming an affect; also in relation to the carer's own internal state: for example, when the carer leaves out any reference to her or his own emotional responses while describing the distressing or heart-warming state of the child.

- **Psychological-mindedness in relation to the child's defences**

'The … child's task of building up … the defense organization is made immeasurably more difficult if traumatic experiences have to be endured during the critical period of maturation and development, just as the supporting walls of a house are more open to damage during building operations than after completion.' (A. Freud, 1967: 238)

Children who have experienced severe and chronic neglect and/or abuse are likely to develop ways of coping (in psychoanalytic terms, narcissistic defences) that are self-reliant and at times even omnipotent, while some others disassociate or develop kinetic second-skin defences (Bick, 1968), and so on.

Helping the child to develop healthy ways of coping with challenges and threats to psychic equilibrium is a core element of the psychological parenting of a child. However, without well-informed professional support, carers may well find it impossible to recognize their foster child's difficult, often distressing, behaviours as their means of coping with overwhelming emotional states. Instead they may see such behaviours as something the child does on purpose so as to hurt or humiliate them, or they may feel the child is being wilfully ungrateful. To assess the carers' psychological-mindedness and degree of awareness of what lies behind the child's challenging behaviours, and what is fuelling them, when analysing the data particular attention will be given to the carer's comments that indicate some understanding of the child's coping mechanisms, the child's intentions, or the limitations in the child's ability to manage excessive arousal. As Anne Alvarez states:

> '*Apparent "defences" against frustration and anxiety may in fact be attempts to protect against, overcome or regulate otherwise intolerable frustration or anxiety and arrive at states of safety and trust.*' (Alvarez, 2012: 67)

- **Psychological-mindedness in relation to the child's narrative**

There are many ways in which one could consider a looked-after child's narrative. In more ordinary terms, this is a question of the child's superego functioning and their identification with an individual, family, or community, perhaps with a religion and a set of values, depending on the age when the child was moved. These are significant factors in the development of the child's resilience. The notion of how an individual tells a story has even been developed as a reliable tool for assessing attachment: for example, The Attachment Story Stem Completion Task (ASSCT). (See Hodges et al., 2003.)

However, the issue of narrative is often complicated further by the fact that these children often experience several moves and at different stages of their development.

> *'At each stage of development ... family members have the task of adjusting to the ... emotional climate within the family, boundaries, patterns of interaction and communication. The foster child is faced with the task of adjusting to these normative tasks while transitioning to a new home environment. ... The foster child is unsure of his or her future and lives in a world of uncertainty.'* (Craven & Lee, 2006: 288)

To complicate matters even further, in many cases the foster children are in regular (often tantalizing, often extremely damaging) contact with their birth families.

In her paper 'Multiple families in mind', Margaret Rustin writes: '*The shadow of earlier turbulence is liable to fall on the family when developmental pressures are felt and when anxieties beset family members.*' (Rustin, 1999a: 61)

For many of these children, their life experiences have been so unbearable and so fragmented that the passage of time has no meaning. Their experience of life becomes a cluster or a jumble of moments, with *'confused sense of past, present, and future, where past experiences remain undifferentiated from the present and where an idea of the future is of something just like the past.*' (Canham, 1999: 160) This is reminiscent of the 'flashback' experience that is widely associated with the sudden and unexpected 'reliving' of the past in the present.

Furthermore, O'Callaghan et al. (2012), in their paper entitled 'Narrative analysis of former child soldiers' traumatic experience', refer to the ways in which those children re-tell their traumatic narrative so that it becomes less threatening to their psychic survival. Thus the incoherent narrative becomes an essential defence against breakdown. This is particularly significant when considering the carer's task of providing a foster child with an alternative set of experiences to the traumatizing experiences that brought the child into care in the first place. On the one hand, the child's ways of being and its distressing ways of remembering the past may stir up such anxiety in the carer that the latter may experience this as a threat to their own

psychic equilibrium and may demand that the child adopt new roles in its new family; on the other hand, the child's story may be so compelling that the carer may feel unable to question the child's beliefs. It may also be the case that foster mother and foster father hold differing views on the child's narrative and what is required by way of response.

Lorne Loxterkamp (2009) suggests:

> *'What the child needs most of all is help to come to terms with that loss and its causes, help to manage knowing and understanding the harrowing information that will explain (with greater sophistication as the child matures) why he had to be removed permanently from the birth family. Without this knowledge it is likely that the child will come to be injuriously convinced, for example, that he is blameworthy because he wasn't good enough for his birth parents, or that he is being prevented from returning to his birth parents for no good reason.'* (Loxterkamp, 2009: 434)

In assessing the foster carers for psychological-mindedness in relation to the child's narrative, the research data has been searched for comments reflecting the carer's understanding of how the child's past experiences link to its current presentation and its difficulties in comprehending and making use of relationships; the carer's views on the birth family and the child's contact with birth parents and/or siblings; as well as statements about how these transitions are managed, the child's habits, the child's views of being in care, and so on.

The carer's defences

Having reviewed the various ways in which the carer's psychological-mindedness may aid the child's recovery from the early traumatic experiences, another particular interest of this study is the phenomenon whereby seemingly 'good enough' foster carers become overwhelmed by the child's defensive communications, with the effect that the carers can suddenly lose their capacity to remain psychologically-minded.

When witnessing a traumatized child's distressed and distressing communication, the carer's anxieties are inevitably and naturally aroused, and at times this impacts severely on the carer's capacity to remain psychologically-minded when responding to the child. By means of empathy, the child's heightened emotional states are responded to by an affect in the carer. On top of the normal anxiety aroused by the child's distressing behaviour, the very painful nature of such an exchange can trigger in the carer deeper, more primitive anxieties, whether based on real events in the carer's life or on the carer's imaginative response to their own distress. This experience can trigger threats of some form of profound loss, or shame, or some other deeply feared emotional experience.

In 'Mourning and Melancholia' (1917), in which he introduces the significance of internal object relations, Freud writes about this phenomenon:

> *'Thus the shadow of the object fell upon the ego, and the latter could henceforth be judged by a special agency, as though it were an object, the forsaken object. In this way an object-loss was transformed into an ego-loss and the conflict between the ego and the loved person into a cleavage between the critical agency of the ego and the ego as altered by identification.'* (1917: 249)

In this passage, Freud describes a split within the ego that damages it. It is a common process, which generates defences, that can help us understand the impact of the carers' defences on their capacity for psychological-mindedness in the face of severe challenge from the child. As a development of the above psychic mechanism, Freud's concept of 'splitting' is introduced as a consequence of disavowal, or turning a blind eye (Freud, 1924, 1927). This process is elaborated further in '*An Outline of Psychoanalysis'* (Freud, 1940), and more fully in his paper '*Splitting of the ego in the process of defence'* (Freud, 1940a).

In fact, Freud had referred to defences against anxieties throughout his career, using a variety of formulations (Freud, 1894, 1917, 1926). For the most part, he linked anxieties stemming from fear of loss of the object, or from aggressive and sexual wishes, to defences such as repression, regression, displacement, identification with the aggressor, and idealization; all of which were then developed further by Anna Freud (A. Freud, 1936). Although it is generally understood that defences are operational at all times, Sandler & Anna Freud recognized the following: *'The ego*

welcomes pleasure and will be more ready to defend against unpleasant affects such as pain, longing, and mourning than against pleasurable ones.' (Sandler & Freud, 1985: 259) However, the looked-after children in this study demonstrate that over-excitement, even in relation to normally pleasurable events such as a Christmas party, can be an exception to this general principle.

In contrast to Anna Freud, for whom defence development is later and more diverse, Melanie Klein was convinced that the development of defences takes place in early infancy. Klein also differed from Freud in relation to the underlying cause or trigger of defences. If the Freudian view was that defences are tools in managing anxieties brought about by Oedipal libidinal wishes (typically age 3-5), in the Kleinian view defences are developed and employed principally to manage primitive anxieties created by the death instinct and the infant's own aggressive impulses. In Klein's view, the main source of conflict and anxiety is the expression of love and hate within close relationships, as well as the need to find ways of restraining destructive aggressive or sexual feelings. (Hinshelwood, 1991: 121-135)

Klein recognized some of the defences described by Freud. She also built on the ideas of others: for example, Freud's defence of projection (Breuer & Freud, 1895), Ferenczi on introjections (Ferenczi, 1922), Abraham's introjections-projection cycle (Abraham, 1924), which she develops further, in her paper 'The importance of symbol formation in the development of the ego' (Klein, 1930), into the defensive mechanisms of expulsion and incorporation. In her 1946 paper, 'Notes on some schizoid mechanisms*', Klein writes about projective identification and splitting of the ego. On splitting, she writes:

> *'I believe that the ego is incapable of splitting the object – internal and external – without a corresponding splitting taking place within the ego. Therefore the phantasies and feelings about the state of the internal object vitally influence the structure of the ego. The more sadism prevails in the process of incorporating the object, and the more the object is felt to be in pieces, the more the ego is in danger of being split in relation to the internalized object fragments.'* (Klein, 1946: 6)

When applied to the present research study, this is especially true of the infant who is dependent on a mother whose availability has been severely curtailed by serious mental health issues.

Klein emphasizes that this intimate link between object and ego is based on the notion of phantasy. She continues:

> *'The processes I have described are, of course, bound up with the infant's phantasy-life; and the anxieties which stimulate the mechanism of splitting are also of a phantastic nature. It is in phantasy that the infant splits the object and the self, but the effect of this phantasy is a very real one, because it leads to feelings and relations (and later on, thought-processes) being in fact cut off from one another.'* (ibid: 6)

Klein identified two types of primitive anxieties: the earlier persecutory anxiety, which is an anxiety of being attacked and falling apart; and the other depressive anxiety, which includes guilt. These anxieties are responded to by two different sets of defences: paranoid-schizoid and depressive.

In the paranoid-schizoid position, one employs '*various typical defences of early ego, such as the mechanisms of splitting the object and the impulses, idealization, denial of inner and outer reality and the stifling of emotions.'* (Klein, 1946: 2)

The depressive position employs manic defences, such as omnipotence, denial of the true qualities of the object, a sense of triumph over the object, or contemptuous control of an object by making it dependent. The characteristic defence against guilt, according to Klein, is an attempt to repair, a form of sublimation of guilt into constructive action.

There has been considerable variation in how the wide range of concepts related to defences have been understood and used by subsequent authors, such as Wilfred Bion (1962), Hanna Segal (1964), Thomas Ogden (1986), Joseph Sandler (1987), Herbert Rosenfeld (1988), Elizabeth Bott Spillius (1988), Betty Joseph (1989), Robert Young (1994), and Gianna Williams (1997). At times the same concept is used quite differently by different thinkers (Meissner, 1970; 1971; 1972). However, a full review of the psychoanalytic view of the origin and function of defences would considerably exceed the scope of this research study. The key psychoanalytic insight, which is

centrally relevant to this research project, is that all individuals, in the course of their early years and in the face of unbearable pain and distress, unconsciously develop defences to protect themselves from the pain, which provide templates to which they will automatically resort, to protect themselves from painful experiences in their subsequent lives. While such defences will often help a person to lead a satisfying and productive life, they may also bring side-effects that are damaging to the individual's wellbeing, their capacity to relate to others, and as a result, their capacity to be a good-enough carer.

The perspective of Social Services

This research project addresses the enormous emotional pressures placed on the long-term foster carers of looked-after children. The chronic shortage of available foster carers, together with the high demand for them, pose considerable limitations on how the matching process between children in care and adults available and willing to care for them is carried out in practice. The Trafford Services for Children, Young People and Families Report (Pilkington, 2014) recognized that, owing to damagingly long waits for placement, it is not always possible to achieve a perfect match. The author of the report suggests that, when matching a child with a foster family, the following needs of the child have to be considered:

- Contact: a placement that meets the child's assessed contact needs is thought to be one of the most important considerations in selecting an appropriate placement;
- Sibling placement or contact;
- Education;
- Race, culture and language;
- Religion;
- Disability;
- The foster carer's family: *'It is important that the household of the foster carer(s) is considered during the matching process. Wherever possible ask how each member of the household including the carer's birth children will match with the*

child to be placed. Check the carer's assessment information during the matching process.' (Pilkington, 2014: 8);

- Bedrooms;

- Safer Caring Guidelines;

- Introduction to the placement – *'Children should have the opportunity for a period of introduction wherever possible with a proposed carer, so both child and carer can express an informed view of the placement.'* (Pilkington, 2014:9)

In considering the foster child's needs, it is evident from the above list of considerations that the main focus of Social Services is currently on information and practical arrangements: in other words, it seems to be exclusively task-orientated. These are indeed of considerable importance, especially given the fact that for many of these children their basic practical needs – including their medical needs and their need for safety – have never been sufficiently met. The child's birth family and background culture are also given considerable attention by Social Services. While such practical issues should indeed be addressed, the findings of the survey noted below strongly suggest that the ability and willingness of the new foster family to attend to the child's emotional needs should be accorded a bigger role.

Here are some relevant findings from a recent survey of Fostering Network members in England, Wales and Northern Ireland (November 2012 to January 2013).

- Foster carers find that the issues involved in caring for the child change significantly over time. Often this involves reworking the child's past trauma and abuse at different ages.

- Experiences of interaction with the birth family vary considerably, with some of those encounters very challenging. Some foster carers would like more support in dealing with this.

- A significant proportion (48 per cent) of all respondents think that additional or different training is needed to prepare them for long-term foster care. The key issues they identify are:
    - Building permanent attachments with the children and managing relationships with birth families in this context;

- The way that the child may continue to revisit early traumas but in different ways as he/she matures;
- Preparing young people for independence;
- Over half of foster carers feel they get partial support from social workers, and only 29 per cent feel fully supported. Inadequate access to the child's social worker in particular is seen as a recurrent problem.
- Support is critical to the success of long-term placements.
- Inadequate respite care is seen as a big problem by some foster carers. (Tears, 2014: 6-7)

What is being implied when references are made to the perceived need for more training and information? Could it be that the perceived deficit is not with respect to the information provided by Social Services, but rather an implicit reference to the fact that one can hardly be prepared by means of information alone for the emotional impact these traumatized children have on their foster family? This survey of foster carers suggests that more thought (and professional resources) should be devoted to anticipating the carers' emotional needs and fostering more effective relationships between the child, the new carer(s), and the systems around them.

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

Summary

The foregoing literature review on the theme of infantile and early childhood trauma and its long-term effects has clearly demonstrated the pivotal role trauma plays in the lives of looked-after children, their carers, and the wider system around them. Since the aim of the study was to explore the impact of psychoanalytically-informed short-term parent support on the foster placement, the selection of further theoretical concepts was guided by the analysis of the research material. The rest of the literature

review therefore focused on the following psychoanalytic concepts: psychological-mindedness and its relation to empathy and insight, psychological-mindedness and its relation to affects and bodily states, as well as the traumatized child's defences and the child's narrative. The data analysis also revealed the key importance of such psychoanalytic concepts as defences and the compulsion to repeat. These links between the research data and the literature review will become more evident in the chapters on the data analysis and the research findings.

The literature review concluded with a brief consideration of the role of Social Services in matching looked-after children with suitable carers and in supporting the placement.

Chapter 6: Research methods literature review

6.1 Psychoanalytically-informed clinical case study

6.2 Grounded Theory

Research methods literature review

This study uses psychoanalytically-informed clinical case study methodology in conjunction with Grounded Theory. These methods were chosen as they allow for the research to be conducted 'in the real world', recognizing the role of colloquial language and discourse, as well as recognizing life and research as a process consisting of a set of dynamic interactions, concerned with individual persons and relations to others rather than actuarial statistics and variables.

6.1   Psychoanalytically-informed clinical case study

Nick Midgley's (2006) paper, 'The *"inseparable bond between cure and research"*: clinical case study as a method of psychoanalytic inquiry', was found to be a particularly relevant account of the historical and scientific aspects of the clinical case study research method. The clinical case study was already a well-established research methodology when Breuer and Freud came to publish their '*Studies on Hysteria'* in 1895. The clinical case study of children began with Sigmund Freud's 1909 account of Little Hans in '*Analysis of a Phobia in a Five-Year-Old Boy'*. An influential development was the publication of Melanie Klein's (1961) '*Narrative of a Child Analysis*'. Although this methodology implies a clear focus on an individual child, its contribution to clinical practice and teaching and the development of new ideas has been widely acknowledged: for example, the impact of the work of Donald Winnicott (especially his case study '*The Piggle'* (1977)) and of many other child psychotherapists.

Midgley (2006: 125) describes how, already in the mid-1930s, the case study fell out of favour amongst social science researchers, as the statistical, randomized trial and other types of methodology emerged and eventually became dominant.

Nevertheless, Michael Rustin (2009) has insisted that clinical case study is an established and valid research method in psychoanalysis, with the consulting room as its '*laboratory'*. In response to Peter Fonagy's (2003) attack on the '*anecdotal'* nature of the data gathered in clinical case studies, Rustin claims that the individual and

collective work of clinicians has, over several generations, created a *'virtual library'* of resources for naming, explaining, and linking clinical phenomena.

> *'One would expect that psychoanalysis, with its particular object of knowledge, namely unconscious mental process, would come to have particular methods of research designed specifically for the understanding of this object and its qualities.'* (Rustin, 2009: 45)

Midgley (2006) groups the criticisms of case study methodology into three broad areas. Firstly, the basic observations or data that are used in the clinical case study are held to be unreliable. Secondly, the ways in which those basic observations are analysed do not allow assessment of the truth or accuracy of any particular interpretation or hypothesis. Thirdly, the generalizability problem: even if the basic data of the case study are considered reliable and they are analysed in a way that makes the interpretation credible, this approach is of limited value because it is not possible to generalize beyond the particular case.

Despite these reservations regarding the generalizability of clinical case findings, there is widespread acknowledgement that clinical case methodology can offer uniquely valuable access to the inner world of unconscious mental processes. No other psychology methodology has the capacity to get beneath the superficial presentation of any individual subject, whether adult or child; to get behind the defensive facade erected by the individual and gain privileged access to subjective psychic reality. While it could be argued that each clinical case study in itself 'proves' nothing, each case study in itself contributes a uniquely instructive piece of a much larger collective mosaic that enables the wider scientific community to grope towards a fuller understanding of the deep recesses of the human mind.

Despite the acknowledged limitations of the clinical case study, the present research study is rooted in Freud's conviction that it is '*impossible to treat a patient without learning something new*'. (Freud, 1927: 256) While the research subjects in this study have not been 'in treatment', their words have been carefully listened to, and subsequently analysed, with the same psychoanalytic skills (in particular, the use of the researcher's countertransference) as if they were in treatment.

6.2   Grounded Theory

Grounded Theory was developed in the 1960s by Glaser & Strauss (1965, 1967, 1968; Strauss & Glaser, 1970) and further elaborated by a range of authors in the field of qualitative research, such as Charmaz (1983, 1990, 2006), Glaser (1978), Strauss & Corbin (1993, 1998), Corbin & Strauss (2008), Pidgeon & Henwood (1998), Chamberlain (1999), and others. Thus, Grounded Theory is a method in process as well as a method designed to analyse process.

Grounded Theory is a research method that can be used to analyse either quantitative or qualitative data, or both. Developed primarily for sociology and anthropology, it is a particularly useful method for studying human behaviour and suitable for a great variety of data, such as interview transcripts, observations, and documents. In other words, it is well suited for data where all the variables cannot be controlled: for example, psychoanalytic psychotherapy and other professions studying complex human data. Janine Sternberg (2005: 219), quoting Strauss et al. (1999), points out that *'in qualitative research the researcher is not trying to control the variables but, rather, to discover them.'*

The purpose of this methodology is to generate theory from qualitative material that will *'give rise to relevant predictions, explanations, interpretations and applications'* (Glaser & Strauss, 1967: 1). It does not aspire to generating proof. The researcher approaches the data initially without a hypothesis and the raw qualitative data is scrutinized and coded. Corbin & Strauss (2008) mainly consider projects where the data is gathered from interviews, similar in format to psychoanalytic sessions, where different views emerge, from different research subjects, in the same area of interest, thus providing variations on a number of themes. In Grounded Theory this is referred to as '*triangulation'* (Denzin, 1971). Fonagy & Moran (1993) emphasize the use of data from multiple sources as a way of improving credibility in qualitative research. Michael Rustin (1991: 120) writes that, from the publication of Thomas Kuhn (1970) onwards, sociologists and philosophers of science have come to recognize that scientific knowledge is based on networks of interlocking and interdependent theories, supported by observational data at many different points.

Once the data is gathered, recorded, and transcribed, it can then be coded. This is referred to as '*open coding'*. However, in this regard I agree with Barney Glaser's

approach of indeed keeping the initial coding open-ended yet acknowledging that researchers possess prior knowledge and skills. As Ian Dey (1999: 251) states, *'There is a difference between an open mind and an empty head.'* (Quoted in Charmaz, 2006: 48)

From these initial codes, categories emerge that are used to organize further thinking. When some categories appear to be related to each other, it becomes possible to suggest hypotheses. One main category may be identified that seems to organize the material: this is referred to as a '*core category'*. Each category has properties whose descriptions are added to by re-visiting the data and making '*memos'*, until a point is reached when further analysis of data adds no more detail. Throughout this process, findings are checked and re-checked against the data by a process called the '*constant comparative method'*: a way of combing through the material to extract as much detail as possible, thus 'grounding' the theory in the data. It is even recommended by some of the pioneers in this area that literature research be carried out only after the data has been analysed, and only then used to expand on the categories already identified by the analysis of data. This recommendation has, however, become the subject of lively controversy. (See Dunne, 2011; and also the brief discussion of this issue at the beginning of Chapter 5, p. 36 above.)

Once no new element of meaning can be added to the category, it becomes 'saturated'. This permits the researcher to check emerging hypotheses, which in turn leads to the development of theory. The first type of theory developed will be a '*substantive theory'* about the subject, and from there it may be possible to develop a broader, more abstract theory, which Glaser & Strauss refer to as '*formal theory'*. The theory thus generated must be relevant to the problem area, it must fit the data, and it must produce explanation or understanding, and thus unite the research process with theoretical development. However, it may also turn out that this theory, while arising from this particular set of data, can also be applied beyond this particular field of research.

There are considerable variations in theorizing about Grounded Theory. In the present study it is used most closely in line with the approach of Kathy Charmaz, itself rooted in social constructionism. This approach is particularly relevant when considering looked-after children, their foster families and the system around them. Her use of

Grounded Theory is based on some Marxist principles: that the world is created by people's actions, and that the existence of social structures depends on people's routines that verify them. Every foster carer, every social worker, and every professional in a looked-after child's life has the potential of contributing to a deeper understanding of the child's experience and the wider care system, and beyond.

Child psychotherapy training lends itself well to the use and development of Grounded Theory, in that the therapist learns to use 'natural language' in communicating with the wider systems, thereby making complex concepts and psychological processes accessible to those unfamiliar with the discourse of psychoanalytic thinking. With the rapidly developing interest in research among psychoanalytic child psychotherapists in recent times, many have chosen Grounded Theory as their preferred method for analysing their data: for example, Reid (2003), Anderson (2006), Hindle (2007), Sternberg (2005), Kenrick (2009, 2010), and Wakelyn (2011).

In this study, I have tried to be as faithful as possible to the carers' words and actions, as well as my own emotional and verbal responses. All have been recorded in the transcripts of the audio recordings. Furthermore, deeply conscious of David Tuckett's warning of '*the possibility that a good, well-told and coherent story creates the risk of seduction'* (Tuckett, 1993: 1183), with the clinician 'heroine' overcoming all obstacles to demonstrate the triumph of the psychoanalytic method, I have striven to report accurately the many complexities, difficulties and (sometimes) apparent contradictions thrown up by this study, as well as my own clinical and theoretical difficulties in conducting it.

Chapter 7: Analysis of the data

7.1   Coding Stage 1: Initial reading of the data

- Open coding
- Verification of initial codes

7.2   Coding Stage 2: Returning to the data

- Developing a system of categories
- Memos
- The core category of 'psychological-mindedness'
- Sub-categories of 'psychological-mindedness'
- Hypothesis 1
- Testing the hypothesis

7.3   Coding Stage 3: Refining the categories

7.4   Coding Stage 4: Emerging theory

- Hypothesis 2
- Getting stuck
- Returning to the data

7.5   Coding Stage 5: Narrowing the focus to the child's communication of distress or trauma

7.6   Coding Stage 6: Development of theory on the organization of carers' responses in relation to the child's communication of distress or trauma

7.7   Coding Stage 7: Psychological-mindedness and defences

Analysis of the data

Coding Stage 1: Initial reading of the data

- **Open coding**

The initial data analysis began by reading through the transcripts of each of the sessions with Mrs Morgan (FM1), noting and analysing themes as they emerged paragraph by paragraph, as is commonly practised by psychoanalytic child psychotherapists. In this case, however, the data consisted of full transcriptions of audio recordings of the sessions and not the usual process notes. This provided immensely detailed content, including some distressing accounts of the child's early experiences, at times making the transcripts very difficult reading material. It is possible that by opting instead for the usual recording process, viz., writing process notes after the session has ended, some of this material would have been processed more gradually, filtered through the various stages of memorizing and recording, or even defended against and lost altogether. One disadvantage of using audio recordings was the dilution in the transcripts of the researcher's immediate countertransference experiences and observations in the room; however, some of that countertransference experience was captured in the words of the researcher that form part of the recording of the sessions (and thus part of the research data).

It could be objected that the researcher brings her own personal bias to the analysis of the data; and this is undoubtedly a potential drawback of the chosen research method. This could impact on the analysis to the extent that the researcher heard the research subjects' words and observed their behaviour in the sessions, and again heard the words of the audio recordings, through the filters of her own experience. However, in mitigation, it has to be stated that this research material could not have been gathered any other way; and also, since the child research subjects and their carers were interacting with this particular researcher, who in turn subsequently read and reflected on the audio data, this in fact in itself brings the research to life in a uniquely valuable way.

- **Verification of initial codes**

Once the emerging themes were identified for all four sessions with Mrs Morgan, these sessions were presented for a series of private supervision sessions with a senior clinician with a dual training, in both child psychoanalytic psychotherapy and adult psychoanalysis. As a result of these supervision sessions, some additional notes and themes were added. Taken together, this initial analysis resulted in a basic framework of themes gathered in the sessions with Mrs Morgan, which could then be tested against the rest of the research participants. (See Charmaz, 1995.) The themes emerged from both the thematic analysis of the dialogue and a psychoanalytic analysis of the dynamics at play between the carer and the researcher.

1) The analysis of psycho-dynamics:
   - The dynamics in the room, i.e., transference and countertransference relationships between the therapist/researcher and the carer(s)
   - The dynamics of the foster carer couple
   - The dynamics of the carer's internal world
   - The dynamics of the child's presentation as it was re-presented by the carer: for example, representation of the child's internal world, affect regulation issues, defences, interpersonal relationships, the child's view of self, etc.

2) The themes:
   - How the carer(s) viewed their role in relation to the child in their care
   - How the carer(s) described the child
   - How the carer(s) viewed the system around them: for example, how Social Services or the therapist are seen and used by the carers
   - How the carer(s) viewed the child's contact with birth parents and siblings
   - More specific themes that carers wanted to think about in the session, such as how to deal with special occasions, such as Christmas, or issues related to food, or how to deal with the child's worries that the carer has forgotten about them ('out of sight out of mind' type of issues), etc.
   - How the therapist experienced and responded to the presented material.

Coding Stage 2: Returning to the data

Once Coding Stage 1 was completed, these initial ideas were tested on the rest of the research material: viz., the sessions with the other participants (Family 2; F3; F4; F5). This produced a vast amount of data that required some kind of systematization in order for it to be manageable and consistent in the task of analysing the data of the other families. Using the themes identified from the analysis of all the sessions, a table was designed that would provide a shorthand representation of the themes and dynamics mentioned in the section above, using a set of keys.

- **Developing a system of categories**

The shorthand identifiers consist of a number (representing an object or a person that is being viewed or experienced) and a letter (representing an individual viewpoint) that corresponds to a certain theme: for example, the foster mother's view (B) of the child (1) is represented by 1B; the foster father's view of the child's birth family is represented by 6C, and so on. This not only allowed identification and tabulation of how frequently themes emerged in a particular session, but also permits a systematic comparison of the frequency of occurrence within the same family over a number of sessions, as well as with other families.

Statements in the sessions were numbered by paragraph (with some paragraphs containing more than one statement), allowing the examination to return easily to the verbal content and link any statement with other statements, in the overall context of the material and vice versa. This will be demonstrated in more detail in the chapter on findings. The table of identifier keys is reproduced below.

TABLE 1 - Key codes

	1 C	2 FM	3 FF	4 T	5 LAC serv.& network	6 Child's birth family	7 Siblings	8 Child's internal world	9 FM's internal world	10 FF's internal world	11 T's internal world
A Child's view	1A	2A	3A	4A	5A	6A	7A	8A	9A	10A	11A
B Foster mother's view	1B	2B	3B	4B	5B	6B	7B	8B	9B	10B	11B
C Foster father's view	1C	2C	3C	4C	5C	6C	7C	8C	9C	10C	11C
D Therapist's interpretation	1D	2D	3D	4D	5D	6D	7D	8D	9D	10D	11D
E Psychological mindedness	1E	2E	3E	4E	5E	6E	7E	8E	9E	10E	11E
F Body awareness	1F	2F	3F	4F	5F	6F	7F	8F	9F	10F	11F
G Affects	1G	2G	3G	4G	5G	6G	7G	Ontologically not existent			
H Defences	1H	2H	3H	4H	5H	6H	7H				
I Coherence of the narrative of the self	1I	2I	3I	4I	5I	6I	7I				

Although not all of the categories in Table 1were present during the analysis of Mrs Morgan's session data, they were included in the table as possible categories, unless they were ontologically non-existent (i.e., a relationship that could not possibly happen). It is important to bear in mind that this coding reflects the themes most frequently referred to, which does not always accurately reflect their significance.

As can be seen from Table 1, a particularly significant role was allocated to the category of psychological-mindedness and its sub-categories, because of its centrality in the work with the foster carers. This method of coding allowed the researcher to track and compare the various expressions of a carer's degree of psychological-mindedness, and also the focus of the therapist's interpretations and comments on the material presented by the carers. This will be considered in more detail later, in the chapter on findings. (It should be noted that during the process of coding, some codes and categories emerged almost simultaneously: for example, the categories of 'psychological-mindedness' of the carer and the 'therapist's focus'.)

At this stage of coding, the material was re-read once more and re-coded using the new, shorthand, code presented in Table 1. As a result of this process, below is an extract from Mrs Winters' 1ˢᵗ session, with the Table 1 codes in column 1.

TABLE 2 - Coding Stage 2

Code	General coding	2E	2F	2G	2H	2I	3E	3F	3G	3H	3I	CH	FP	No	Session
												-1		1	T: Would you say he was a bit too placid?
1B	'I think he was just frightened, I think it was all fear in him'	1	1	1										2	FM: **I think he was just frightened, I think it was all fear in him**. Cause **he used to scream, he used to get himself in a state** didn't he? And he used to scream and **he could scream for two or three hours solid and whatever we did we couldn't bring him out of it**. We don't know why he did it, but he would scream constantly.
2E	Empathy and emotional attunement														
2G	Consideration given to the child's affect														
2F	Screaming as child's communication														
1B	'he used to scream, he used to get himself in a state'														
1B	'he could scream for two or three hours solid and whatever we did we couldn't bring him out of it'														
8B	Awareness of internal dynamics in the child														

Particular attention had to be paid to the challenge of bearing in mind various points of view simultaneously: viz., the foster mother's (FM); the foster father's (FF); the therapist's (T); the child's (as reported by the carers); the birth family's (BF); siblings (SI); and the perspective of the wider network (SY); also bearing in mind the intrapsychic or internal psycho-dynamics. Often this required repeated reading of the material. Below is a schematic representation of these complex dynamics, which illustrates the intricate interplay of multiple objects and multiple internal worlds.

DIAGRAM 1 – Intra-Psychic Dynamics
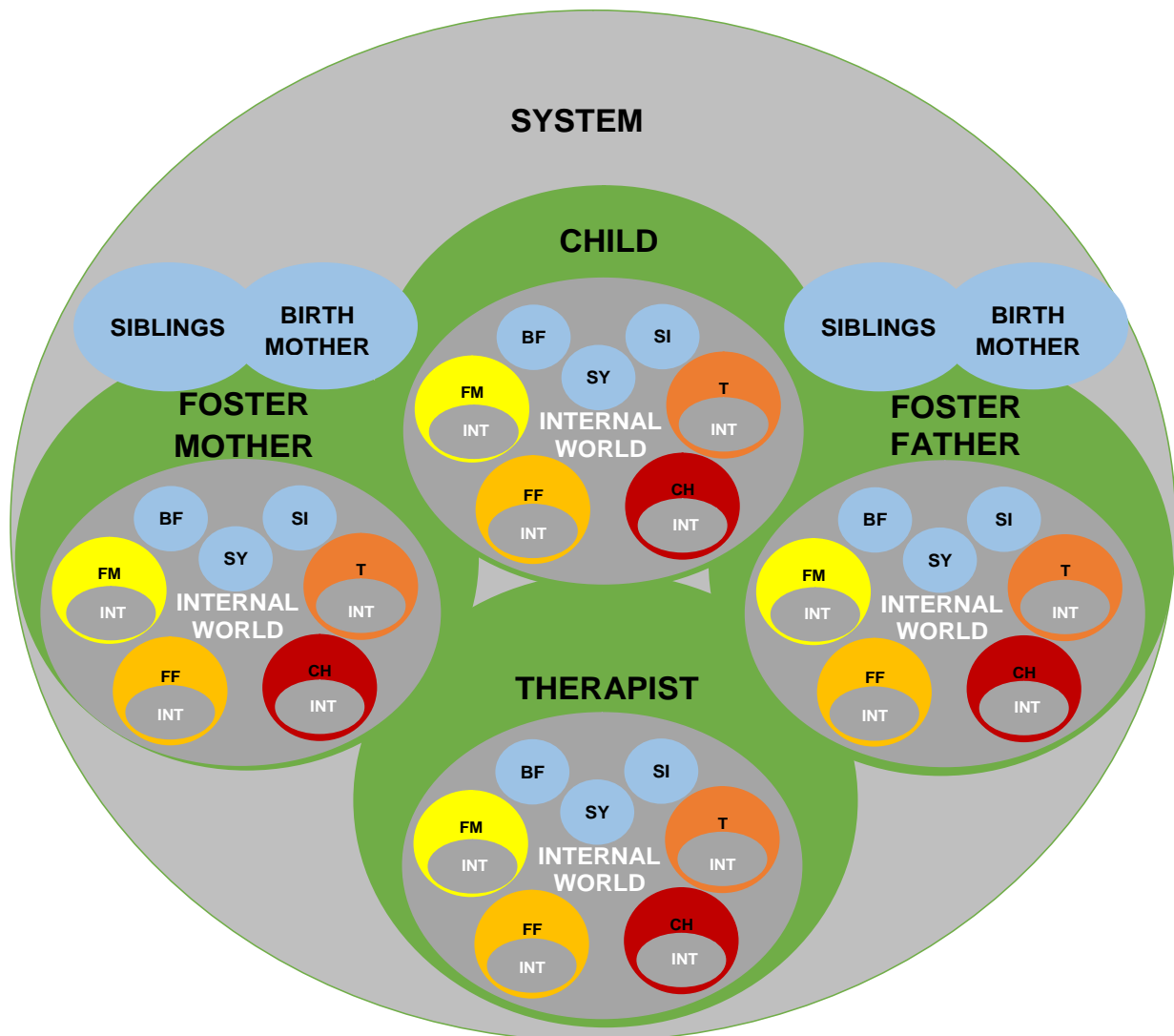
- **Memos**

Alongside and throughout this activity of coding, notes were made by the researcher, in the form that practitioners of Grounded Theory refer to as 'memos' (Charmaz, 1995). Memos consist of the researcher's free associations to the material while coding, to discussions in supervision sessions, etc. From this point onwards, the researcher's journal of memos was kept throughout the whole of the coding process. These memos usually contained a reference to the source, such as the family code, session number and statement number; or if the memo was in relation to the coding, it was the code

number. Some of these comments were of a qualitative nature, forming the basis for some of the development of further theoretical thinking, at other times forming the basis for a section in the Findings chapter (for example, the section on 'Psychological-mindedness in the couple'); while other comments had a more practical purpose, e.g., about the process of coding. Here are two examples of such recorded memos.

TABLE 3 – Memo sample

8;9;10;11 B&C	Dimensionality of the couple. Think about how the ability to keep the other person in mind is demonstrated in the couple, i.e. in the example of selected group the foster father was present or absent physically, but also present or absent mentally. FF1 = physically absent and mentally absent from FM1 mind FF2 = physically absent and mentally absent from FM2 mind FF3= physically present and mentally present, present in FM3 mind FF4= physically present and absent and mentally present in FM4 mind FF5 = physically absent and mentally present in FM5 mind Is there a feel of an Oedipal couple in the foster mother's mind being modelled to a child? Can the child witness how she/he could be kept in mind? Think about the idea of the couple as essential in developing awareness about the 3D (the couple may include a sibling).
F4S1P142-p146	The impact the change of social worker has on the child and the foster family.

- **The core category of 'psychological-mindedness'**

From the analysis of the material presented by Mrs Morgan, a more specific question also emerged:

What is the quality and depth of psychological-mindedness the carer or carers display in relation to the child in their care?

For the purpose of this analysis, I am using Stephen Appelbaum's definition of psychological-mindedness: '… a *person's ability to see relationships among thoughts, feelings, and actions, with the goal of learning the meanings and causes of his experiences and behaviour.*' (Appelbaum, 1973: 36)

Hope Conte et al. (1996) extended the concept of psychological-mindedness beyond mere self-focus, pointing out that it involves '*both self-understanding and an interest in the motivation and behaviour of others*' (1996: 251), an extension of application that is highly relevant to this study.

- **Sub-categories of 'psychological-mindedness'**

From a further reading of the material, it became apparent that there are several ways in which the carers were able to demonstrate their psychological-mindedness in relation to the child in their care. There may well be more, but the sub-categories identified from this material that are relevant to this research were the following:

- An insightful comment (or conversely an absence of insight) about the child, indicating the carer's ability to make links, have insights and empathize with the child (later coded, as in the table below, as 2E for the foster mother or 3E for the foster father);

- The carer's awareness (or lack of awareness) of the child's bodily states and communication through physical expression (2F & 3F);

- The carer's awareness (or lack of awareness) of the child's affect (2G & 3G);

- The carer's awareness of the child's ways of coping: i.e., references made by the carer to the child's defence mechanisms, including occasions when the carer is not aware of making such references to defences (2H & 3H);

- The carer's ability (or absence of ability) to make links between the child's past experiences and presenting difficulties (2I & 3I).

- **Hypothesis 1**

This led to a follow-up question: What were the facilitating factors (if any) that fostered this psychological-mindedness during the psychoanalytically-informed parent support work?

From the analysed material of Mrs Morgan's sessions emerged a hypothesis that the carer's ability to sustain psychologically-minded thinking towards the child was directly correlated to the therapist's attentiveness to the carer's emotional states (which can be termed 'the therapist's focus'). In other words:

the more the therapist focused on the carer and the carer's emotional states in the course of the parent work, the more the carer was enabled to focus on the child's emotional needs.

- **Testing the hypothesis**

To test this hypothesis, it was necessary to track throughout the data and then tabulate the timing and frequency of the therapist's focus, represented as either 8D (focus on the child) or 9D/10D (focus on the foster mother or father) (see Table 1 above): i.e., when interpretations or comments by the therapist were directed towards either the foster carer(s) (FC, see example below) or the foster child (CH). These instances of 'therapist's focus' were then correlated with instances of the carer's psychological-mindedness towards the child.

To indicate the presence or absence of such a psychological-minded insight, a simple counting of +1 or -1 was used at this stage of coding. This is a simply quantitative rather than a qualitative account. (See Table 4 below.) If no such statement was made, the utterance was counted as 0. The evaluation of the carers' statements in this study was informed by what would be widely recognized as the psychoanalytic mode of listening.

The example of Mrs Morgan in Session 1 (see Table 4 below, F1S1 [Family 1, Session 1]), in which each row represents a paragraph of the session material, demonstrates the degree of psychological-mindedness in the foster mother (FM) in the following sub-categories:

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- 2E –   insightful comments
- 2F –   awareness of the child's bodily states
- 2G –   awareness of the child's affect
- 2H –   the carer's ability to recognize the child's defences
- 2I –   the carer's ability to make links between the child's presenting difficulties and the child's past experiences.

[Mr Morgan (3E, 3F, 3G, 3H, and 3I) has a score of 0 throughout as he had chosen not to take part in this research project.]

The columns in blue in the table below represent the direction of focus of utterances of the therapist (T), where -1 represents the therapist's utterance being focused on the child (CH) and +1 represents the therapist's utterance being focused on the carer (FC). [Unlike the scores for the carers (in the green and amber columns), it is important to note that +/- do not in this table represent the presence or absence of awareness; the use of +/- here is a technicality to enable the researcher to represent these findings in a later graph.] The idea of tracking the direction of the therapist's focus (either on the carer or on the child) arose from the new hypothesis that the shifts in carers' capacity for psychological-mindedness correlate with the direction of the therapist's focus, either on the carer(s) or on the child.

TABLE 4 – Sample coding of psychological-mindedness in one carer

Mrs Morgan Session 1 (F1S1)

Paragraph Number	2E	2F	2G	2H	2I		3E	3F	3G	3H	3I		CH	FC	
Total	-14	11	12	-9	-6	-6	0	0	0	0	0	0	-54	13	-41
1	-1		1			0						0			0
2						0						0	-1		-1
3	-1				1	0						0			0

… and so on for every statement made in the session. For the full table of all the codings made for this session, see Appendix 2.

The purpose of this table was to enable summarizing and tracking of the changes in the carers' psychological-mindedness (2E; 2F; 2G; 2H; 2I and 3E; 3F; 3G; 3H; 3I) and the therapist's focus (CH; FC) in the course of the session. For details of how this table was thus used, see the section on Findings, Graphs 1 & 2.

Coding Stage 3: Refining the categories

Once all the sessions for all of the five families (a total of almost 1,000 pages of transcripts) were read and coded, to ensure consistency of the coding throughout the material the data was reviewed once more to examine if or to what extent the coding had changed from the beginning of coding through the process of coding: i.e., the coding was checked for consistency. The memos were used to clarify and refine the researcher's thinking about the use of particular codes, and some adjustments were made.

Coding Stage 4: Emerging theory

While reading and re-reading the material, it became evident from the foster carers' statements that their relationship to the child in their care (1B & 1C) and their view of their own role as carers (2B & 2C) kept changing throughout the sessions: for example, at times they felt emotionally closer to the child they were caring for, in a way that an effective parent would; while at other times, they adopted more distant, more 'professional'-type stratagems to help them manage the challenges presented by the child.

- **Hypothesis 2**

It became clear that there were times when something about the foster child felt unbearably distressing for the carer. At these times of extreme distress, and the consequent emotional challenge for the carers, they tended to respond to the child in their own individual way, according to their own unique ways of coping. Their responses seemed to vary greatly from individual to individual. However, one significant pattern of response emerged from the data.

In reaction to the child's distress, the response of each carer could be plotted at some point along a spectrum, from either distancing themselves from the child to seeking excessive closeness with the child.

This observation pointed to a particularly important function of the therapeutic support that can assist the foster carer in achieving a more balanced, and more rounded, view of the child, which would allow the carer to gain appropriate and sufficient understanding of the child's trauma without becoming overwhelmed by it. Furthermore, a fuller understanding of these supportive processes at work in the therapeutic setting could potentially play a significant role in facilitating more effective liaison between the carers and the professional system around them.

(Interestingly, similar parallel processes of distancing and closeness were observed to be taking place with respect to the carer's relationship to the wider system and the researcher's relationship to the material. This phenomenon will be discussed further in the chapter on findings.)

- **Getting stuck**

This new hypothesis then required a further detailed assessment of the carers' responses to the child, as revealed in the course of the research sessions. Although these themes were already coded in the text, a closer examination of the qualitative nature of these variations now seemed necessary. The straightforward selection of these sections of the overall coding – 1B, 1C, 2B, 2C, 3B and 3C (describing the carers' feelings and thoughts about the child, and about themselves in relation to the child; see Table 1 above) – alone confirmed the fact of change, but did not sufficiently

provide the qualitative context within which the foster carers were making these statements: i.e., the relational dynamics were lost in the process. Therefore, in order to trace these dynamics more closely, further open coding was required (Charmaz, 1995).

- **Returning to the data**

It soon became evident that this approach presented a considerable challenge in creating new categories, owing to the large number of variables. After repeated examination of the data and testing of various categories, the conclusion was reached that in order to reduce the unmanageable number of variables, a further question needed to be posed that would allow a narrowing of the field of search. Eventually the following research question was created, based on the researcher's overall countertransference to the material:

What is the foster carer's response to the child's communication of distress or trauma?

This necessitated yet another reading of the material, selecting particular sections within which the foster carer was, knowingly or unknowingly, referring to the child's communication of distress or trauma.

Coding Stage 5: Narrowing the focus to the child's communication of distress or trauma

At this stage, the coding process was moving from open coding to concentrating on those statements in which the carers reported their own internal or external responses to the child's communication of distress indicative of the reliving of trauma. Owing to the very large quantity of such material, it was considered necessary to restrict the data for this analysis to the first and last sessions of each family, so as to capture the change that occurs over the four sessions (Coding Stage 5). The following extracts have been selected to demonstrate how this analysis was deduced from the carers' statements.

Mrs Morgan, session 1, paragraph 57

'…She can be a wee bit bossy at times. She forgets that I'm the boss, type of thing.'

- **No meaning ascribed to the child's actions**

Mrs Woods, session 1, paragraphs 177 & 185

'… But the wee granddaughter, the other week, had a wee egg, and Madison broke it, you know. She just… I don't know if she did it deliberately or not, but my granddaughter was standing crying and there was a wee pigeon in it, a wee chick. So she was distraught, but Madison probably hadn't realized that it would have broken…'

(…)

'Uhuh, yeah, but he [the foster father] didn't really need it [the egg], 'cos he wouldn't have given it to the grandchild, 'cos she would have broke it, you know. So it wasn't needed or anything. It didn't matter to us, you know.'

- **Denial of the child's murderous feelings**

Mrs Winters, session 1, paragraphs 66 & 69

'I think he was just frightened, I think it was all fear in him. He used to scream, he used to get himself in a state, didn't he? (Turns towards the foster father.) And he used to scream and he could scream for two or three hours solid and whatever we did we couldn't bring him out of it. We don't know why he did it, but he would scream constantly.'

(...) 'And no matter how much you tried to coax him round or, you know, trying to get him interested in something, he would just continually scream. It was like something had triggered in his head, that something had either frightened him or em… and…, and it took us a couple of years, more than a couple of years, to get him over that, the screaming.... '

- **Assuming responsibility for the child's recovery**

- **Awareness of the child's internal dynamics**

- **Linking the child's affect with his traumatic past experiences**

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Mr Winters, session 1, paragraph 31

'…he never really asked for his mummy or anything.'
- *Insightful observation*

Mrs Patterson, session 1, paragraph 61

'*They asked me had he that, you know, that ADH, whatever you call it. Whether he wants to be centre of attention or whether he wants to be that, but when you get it 24/7, it just drags you down. I got now… I don't want to get out of bed in the mornings… some mornings. Now he's been good this week.*'
- *Distancing*
- *Overwhelmed*
- *Naming the impact on the carer*

Mr Patterson, session 1, paragraph 207

'*To me all you are doing at fostering is loving a child, that's all you can do, like. But he doesn't allow you to love him, he won't let you do that.*'
- *Insight*

Mrs Stewart, session 1, paragraph 18

'*It takes you a while to break through to Cameron to gain any sort of trust. He really does have a wall. A very steel and sturdy wall to start off with. We wouldn't find him like that now …*
- *Insightful observation*

(…) And I suppose it's part of their coping mechanisms.'
- *Recognizing the child's defences*

These few extracts demonstrate that at times the carer's focus is on the child's needs and at other times their focus is on their own struggle to cope with the states of mind evoked in them by the child's distress. These responses are individual to each carer, even within the same family.

The most significant factor in the child's communications – the factor that generated these responses – was the evidence of the child's distress; and interestingly, the precise type of distress-triggered behaviour presented by the child seems to have had no particular significance in activating the carer's responses. The children's displays

of distress ranged from feeling sad and stroppy to re-enacting traumatic past experiences through impulsive risk-taking behaviour. However, the specific category of distressed behaviour was not a predictor as to how the carers would respond to the child. **What mattered more was the individual carer's capacity to metabolize the child's distressed and distressing communication**. In other words, the children's communications of distress always have the potential of triggering the carer's own trauma responses.

Now, although child-carer matching is a common aspect of social work practice, it clearly has significant limitations, the chronic shortage of available carers being one of them. This raises the question whether, under these everyday supply pressures, the carer's capacity to cope with the onslaught of the traumatized child's affective world is given sufficient consideration in the appointment and allocation of carers? Could psychoanalytically-informed parent work assist this process? Although it lies outside the scope of this research study, this issue will be considered further in the chapter on recommendations.

Coding Stage 6: Development of theory on the organization of carers' responses to the child's communication of distress or trauma

In comparing the carers' responses to their child's communication of distress, it was noted that there are wide variations in those responses. This analysis also identified a pattern, whereby the carers' responses to their child's communication of distress fall into the following categories:

a) **'Good enough'** carer responses;

b) Responses that indicate that the carer has identified with the child's distress and is protecting their own psychic equilibrium by **distancing** themselves from that distress;

c) Responses that indicate that the carer has identified with the child's distress and is attempting to protect the child by psychically **merging** with it, often at the cost of threatening their own psychic equilibrium.

Categories b) and c) above represent two extremes of carers' responses, on opposite ends of a spectrum.

d) As well as, and as distinct from, full identification (by either merging or distancing) taking place, there was also a range of intermediate and less damaging responses, on either side of the spectrum, that fall into a category that one could describe as an **impairment** of the carer's psychological-mindedness. This impairment also seemed to contain some elements of either distancing or merging, but not to the same extreme degree as the categories at either end of the spectrum involving identification with the child. (Cf. Fraiberg et al., 1985).

To help clarify this spectrum from (-2) to (+2) (see Table 5 below), one could say that 'impairment' (-1 or +1) represents the carer's partial identification with the child's distress, while (-2) or (+2) represent more thorough-going identification.

To test this hypothesis further, the data representing the carer's responses to the child's distressed/ traumatized communication was revisited and categorized in more detail. Here are some examples from the carers' statements to illustrate the application of these different categories to the data.

TABLE 5 - Carers' responses to the child's communication of distress or trauma

Identification by distancing	Indication of impairment	'Good enough' carer responses	Indication of impairment	Identification by merging
(-2)	**(-1)**	**(+0-)**	**(+1)**	**(+2)**
In this example, the carer seems to be turning a blind eye to the child's aggressive feelings and thus distancing herself from the child's distress.	In this example, the carer is aware of the child's affect and its causes, but seems to struggle to provide containment.	In this example, the carer is aware of the difficulties, but seems able to remain emotionally available.	In this example, the carer identifies himself with the child, rather than seeking the underlying meaning of the child's refusal to take his medication.	In this example, the carer merges with the child and struggles to make use of the supports at hand.
(FM2_S1_P18)	(FM1_S1_P21)	(FF4_S1_P202)	(FF3_S1_P57)	(FM5_S1_P26)
Well not with me she doesn't, but she would out on the street. She would be angry, so she would, with some of the children now, she would hit out at them, but nothing bad. I would just have to watch her now with my wee granddaughter.	*You see, when she comes back she cries, because she says she misses her sister and her granny and I just say, 'Well, oh dear, because you have to stay with me for the time being because I'm looking after you.' And she says, 'I know that, but I just miss my mummy, my*	*To me, all you are doing at fostering is loving a child, that's all you can do, like. But he doesn't allow you to love him, he won't let you do that.*	*I normally say to him, I'm a diabetic, so I have to take insulin, so he sees me taking insulin, so I say that 'I have to take my medication to make me better so you have to take your medicine to make you feel better.*	*I suppose the one thing I would say to that is that I'm not sure if we will need four sessions then. Cameron is very repetitive and I'm just not sure if I could spend four 50 minute sessions because I would be then repeating myself. He's very the same, most days. If anything, I get to a stage*

	sister and my granny.' That's just the way she takes it.			*where, I guess we all say this in the house, where we feel sorry for him in a way. Because he doesn't see it as being bored but we see him as, you know, he must be bored because he doesn't know how to do things, he doesn't know how to move from one activity to the other. You know?*

These examples demonstrate the impact of the carer's own internal world in coping with a distressed and distressing child. At these times, the robustness of the carer's own internal objects is really put to the test. At one end of the spectrum, the carers become distant by resorting to paranoid-schizoid defences, thus avoiding (temporarily at least) the psychological parenting of the child. At the other end of the spectrum, more depressive, guilt-driven defences come into play, whereby the carer seems to merge with the child's distress and become highly proactive in parenting of the child; however, this carries with it the danger of overlooking his or her own needs for protection from the traumatic experiences repeated and presented by the child. The data indicated that these very dynamics may also be mirrored in the wider system.

Coding Stage 7: Psychological-mindedness and defences

The final stage of coding arose from the researcher's curiosity about whether the variations in sub-categories of psychological-mindedness could provide some further insight into carers' responses to the child in their care. It was noted in an earlier section above that evidence of carers' psychological-mindedness could take various forms:

- Insightful comments
- Awareness of the child's bodily states
- Awareness of the child's affect
- The carer's ability to recognize the child's defences
- The carer's ability to make links between the child's presenting difficulties and the child's past experiences.

At this final stage of coding, these sub-categories were applied to defences and then grouped to see if there is a particular domain in which the carer's responses become more defensive in relation to the distress presented by the child. This is an example from Mrs Morgan's session 1:

TABLE 6 – Psychological-mindedness and defences

Par. No	Foster carer's statement about the child	The initial coding	PM cat.	Short code	Dist./ merg.
1	*Mrs Morgan: It will be 2 years in October, everything's going fine.* **She does get upset sometimes about her mummy** *and stuff like that, you know. She sees her mummy twice a month and* **she can get upset** *when she comes home again, but* **her social worker has explained to**	**Awareness of problematic feelings**	2G 2I	**Awareness**	0

	her that she's staying with me and *she seems to be happy enough* with that, you know.	**Distancing by using Social Services** **Closing down**		**Distancing**	-1
7	*Mrs Morgan: At first, she was very quiet, but not now. She was very quiet;* **she would do, kind of, odd things. Like when she took her clothes off, she always put them in the cupboard, you know, instead of putting them in the laundry basket to be washed, she would fold them up and put them in the cupboard. And I, kind of, had to explain to her then that you really don't do that, you change your clothes every day and put them in the linen basket, you know, that you don't have to do that.** *That was one of the things but she doesn't do that anymore.* **I have to make sure she brushes her teeth** *in the mornings and evenings because* **she had bad teeth** *and she had had to get quite a few teeth out when she came to me, so she did, because they were all bad, you know.* **So that was another thing I had to look for.**	**'Odd things' – communicating the difference between the child and self, also disapproval** **(separateness of narratives)** **Focus on management rather than understanding, and this is expressed by addressing the physical needs, such as medical or hygiene needs**	2F	**No meaning is ascribes to the child's actions** **Assuming responsibility**	-1 0

This chapter has illustrated the application of Grounded Theory and psychoanalytically-informed clinical case study methodology to the material gathered

from the five sets of foster carers over a period of four sessions. It breaks down this process into seven stages of coding, from the initial reading of the data to the eventual development of two key hypotheses. One of the predominant themes that emerged from the analysis was the carer's capacity to remain focused on the child's emotional needs and how this in turn was linked to the direction of the therapist's focus. The successive analyses of the data culminated in the hypothesis that the more the therapist focused on the carer and the carer's emotional states in the course of the parent work, the more the carer was enabled to focus on the child's emotional needs.

As the system of categories emerged according to the themes exemplified in the sessions, a particular focus of analysis became the concept of psychological-mindedness, considered under several sub-categories: displaying insightful comments; awareness of the child's bodily states; awareness of the child's affect; the carer's ability to recognize the child's defences; and the carer's ability to make links between the child's presenting difficulties and the child's past experiences. Through this analysis it became apparent that degree of psychological-mindedness was closely linked to the individual carer's capacity to metabolize the child's distressed and distressing communication. This in turn led to a deeper exploration of the situations that were particularly challenging for the carers: i.e., instances when the child was compelled to repeat past traumatic emotional states and as a result was communicating distress. This exploration eventually generated the second hypothesis: that in reaction to the child's distress, it appeared that the response of each carer could be plotted somewhere along a spectrum, from either distancing themselves from the child's emotional state to seeking excessive closeness with the child (merging). The next stage of the analysis developed four new categories of carer's responses: 'good enough'; identification and merging with the child; identification and distancing from the child; and finally, the category that describes the carer's psychological-mindedness as being 'impaired'. This then led to an exploration of the carer's own defences at these most challenging times.

Chapter 8: Findings

8.1 Psychological-mindedness

- Data summary (Coding Stage 1)
- Data analysis (Coding Stage 2)
    - Foster carers' 'psychological-mindedness'
    - 'The therapist's focus'
- Interim conclusion

8.2 Psychological-mindedness in the couple

8.3 Developments over the four sessions

- The typical pattern
- Deviation from the typical pattern

8.4 The carer's responses to the child's communication of distress or trauma (Coding Stage 5)

- Mrs & Mr Morgan (F1)
    - Their view on fostering as reported by the carer
    - Mrs Morgan, Session 1 – raw list of her responses to the child's communication of distress or trauma
- Mrs & Mr Woods (F2)
    - Their views on fostering as reported by the carer
    - Mrs Woods, Session 1 – raw list of her responses to the child's communication of distress or trauma
- Mrs & Mr Winters (F3)

- Their view on fostering as reported by the carer
- Mrs Morgan, Session 1 – raw list of her responses to the child's communication of distress or trauma

- Mrs & Mr Patterson (F4)
  - Their views on fostering as reported by the carers
  - Mrs & Mr Patterson, Session 1 – raw list of their responses to the child's communication of distress or trauma

- Mrs & Mr Stewart (F5)
  - Their views on fostering as reported by the carer
  - Mrs Stewart, Session 1 – raw list of her responses to the child's communication of distress or trauma

8.5 Further refinement of the responses in foster carers to the child's communication of distress and the compulsion to repeat (Coding Stage 6)

- Carers identify with the child and distance themselves
- Carers identify with and merge with the child
- Carers identify with the child and switch between merging and distancing
- The carer's psychic equilibrium is impaired
- The carer can offer 'good enough' psychological parenting

8.6 Summary of findings

Findings

Psychological-mindedness

The literature review chapter has already summarized the definition and theory of psychological-mindedness as it is used in this study; and the data analysis chapter has demonstrated how this concept emerged from the data. The purpose of this chapter is to bring together the findings of the research project.

- **Data summary (Coding Stage 1)**

The idea of measuring the level and quality of psychological-mindedness in the carers emerged from a careful reading of the transcripts of the sessions with Mrs Morgan (FM1), where the carer (in this case the foster mother) demonstrated some insights and compassion with respect to the child, but at other times a marked absence of those qualities. Although the initial approach was simply to note how frequently the foster carer made a statement that indicated the carer's psychological-mindedness towards the child, it soon became apparent that there is more than one way in which the carers express their interest in understanding the child in their care. This finding was then confirmed by an analysis of the rest of the carers.

The following categories represent the five ways in which psychological-mindedness was accounted for in the data:

- insightful comments (2E & 3E)
- awareness of the child's bodily states (2F & 3F)
- recognition of the child's affect (2G & 3G)
- the carer's ability to recognize the child's defences (2H & 3H)
- the carer's ability to make links between the child's presenting difficulties and the child's past experiences (2I & 3I).

The data also showed that the ways in which the carer's psychological-mindedness shifted during the session correlated with the therapist's focus of interest: i.e., when

her interpretations and comments were directed towards either the carer(s) or the foster child.

- **Data analysis (Coding Stage 2)**

The above data was then collected from every family in every session. In order to demonstrate the findings from the collated data, they will be presented in the form of graphs.

  - **Foster carers' 'psychological-mindedness'**

Here is the example of Mrs Morgan, Session 1, Graph 1. (For the detailed data, see Table 4, p. 95 and Appendix 2; for the graphs of other carers, see Appendix 2.)

GRAPH 1

(Mrs Morgan, session1)
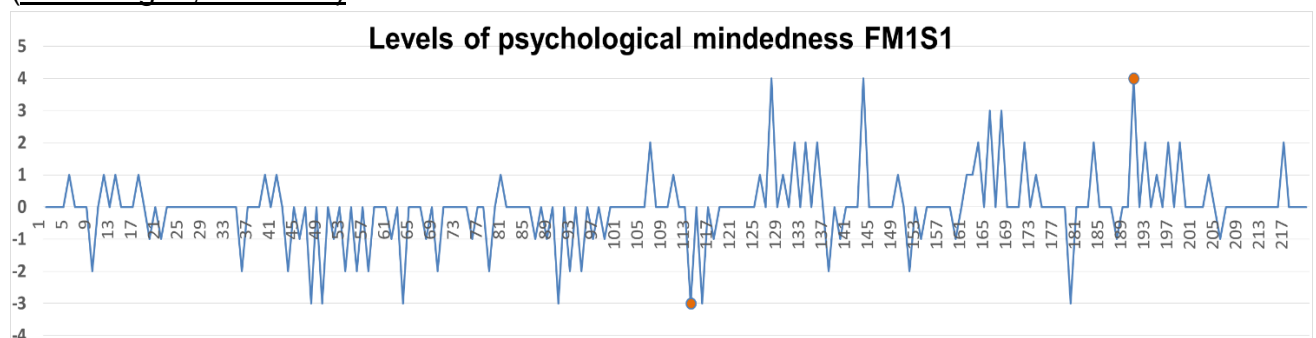
This graph demonstrates how Mrs Morgan (FM1), in her first parent support session (S1), shifts from struggling to be psychologically-minded (below the horizontal axis) to becoming more available to feeling and thinking about the child (above the horizontal axis). The numbers on the horizontal axis in the graph represent a paragraph of the data, making it possible to trace each rise and fall in this variable. Below is an example from paragraph 113 (the red dot below the axis) that scored 3 negative categories of psychological-mindedness (-2G, -2H, -2I): in other words, indicated an absence of psychological-mindedness.

> *And I just say, 'Ach, I know, you do miss your mum, but this is just the way it is at the minute, I'm just here to look after you.'*

However, later in the same session, in paragraph 190 (the red dot above the axis), the last highest peak in the graph represents 4 categories of psychological-mindedness (2E, 2G, 2H, 2I).

> *There are some times when she would hide her feelings, but there are some times when she would say 'I love you', and I obviously would return back 'I love you too'. But she wouldn't say it very often. Maybe I could count it out on my fingers the number of times she has said it to me in the two years she's been with me. I think maybe she's afraid to say it because then she doesn't want to upset her mummy, you know what I mean? That's what I think. She has a loyalty towards me and her mummy as well, she's kind of confused a wee bit probably, about where her loyalties lie, but she'll get there eventually. But at the minute, I am delighted to hear that, it was nice to hear her saying that to me and I said it back, but I wouldn't hear it too often, if you know what I mean.*

As considered earlier in the Literature Review chapter, Melanie Klein's idea of '*projective identification*' (Klein, 1946: 8), Wilfred Bion's later concept of '*container-contained*' (Bion, 1962: 90), and several other psychoanalytic theories describe processes at play between infant and mother, and correspondingly between a patient and a therapist, that could account for this kind of transformation in the psychological-mindedness of the patient. Bion summarizes the positive potential of the process of 'containment' thus: *'Container and contained are susceptible of conjunction and permeation by emotion. Thus conjoined or permeated or both they change in a manner usually described as growth.'* (Bion, 1962: 90) However, in these early encounters between therapist/researcher and foster carers, Donald Winnicott's (1953) idea of a '*holding environment*' seems the most fitting. To explore these inter-psychic processes

further, the following graph was created to demonstrate shifts in the therapist's focus between the child's needs and the carer's needs. (In the case of F1, there will be no graph representing the foster father, since he did not take part in this project.)

- **'The therapist's focus'**

GRAPH 2

(Therapist's focus with Mrs Morgan in session 1)
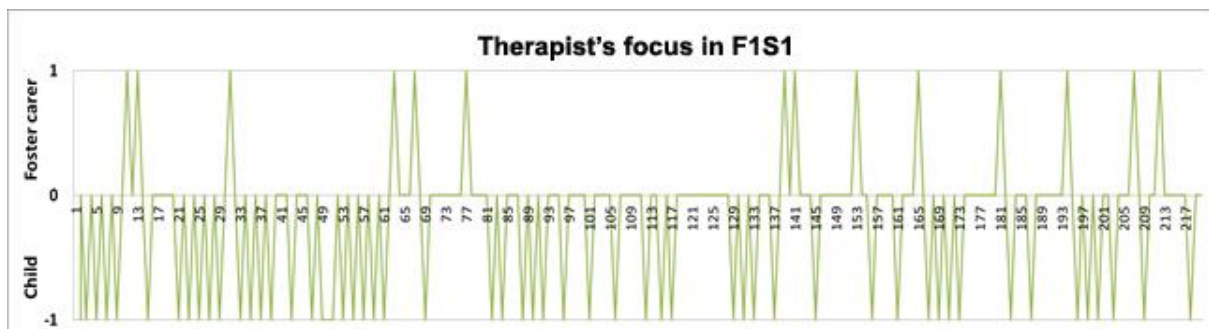
This graph indicates that the therapist's focus at the start of the session is primarily on the child (below the horizontal axis), but towards the end of the session more frequent statements are made by the therapist in relation to the carer as well as the child. This indicates a correlation between the therapist's preoccupation and the carer's capacity for psychological-mindedness towards the child.

Interim conclusion:

Although this is not a new theoretical idea, this finding demonstrates that even within one session of psychoanalytic parent support work, it is possible to bring about an improvement in the extent of the carer's psychological-mindedness.

It is important to acknowledge that each set of carers presented quite differently in this regard: i.e., showing psychological-mindedness (PM) in Session 1 (S1), as is demonstrated in the table below. (See also Appendix 2.)

TABLE 7- Foster carers' 'psychological-mindedness' in Session 1

Participant	FM1	FF1	FM2	FF2	FM3	FF3	FM4	FF4	FM5	FF5
PM S1	-6	N/A	31	N/A	96	13	11	41	37	N/A

For example, Mrs Winters (FM3), already in Session 1, showed a divergent picture with respect to psychological-mindedness from the rest of the group, a score of 96 indicating much higher capacity for psychological-mindedness in the first session; whereas Mrs Morgan's (FM1) score in the first session was -6. And this overall difference was reflected in the fact that the development in psychological-mindedness achieved by Mrs Morgan in the course of Session 1 was not apparent in the case of Mrs Winters. Furthermore, the overall developments in psychological-mindedness (PM) achieved with the other carers over the several sessions were not apparent in Mrs Winters (FM3) either. However, the overall trajectory of change over the course of four sessions was consistent with the initial findings, as will be demonstrated later.

Psychological-mindedness in the couple

Although the sample of participants in this study is small, it also demonstrated that the gender of the carer is not in itself an indicator of their level of psychological-mindedness. This may seem obvious, but it is still significant, especially considering that it seems to be culturally accepted that the female carer usually bears the main responsibility for fostering liaison with other services. The male carer's role is often disregarded. Here is an example from the 1st session with Mrs Patterson & Mr Patterson:

(Mrs Patterson, S1P6-P12)

> Therapist: *So how was it for you to get here?*
> Mrs Patterson: *My husband brought me in the car, he's across the way.*
> Therapist: *He didn't want to come in?*

Mrs Patterson: I never asked him. I was going to now, but then I thought, is this just for me? But he's fine. He's fine.

Therapist: You are both foster carers, it would be quite important.

Mrs Patterson: Yeah I know, I know, and he's very, my husband's very laid back and nice and easy-going. I could go over and get him if you want now?

Therapist: Well, actually I think that would be very helpful.

As mentioned earlier, all five foster families consisted of a foster mother and a foster father, but in fact only two foster fathers attended the sessions, and one of them attended only two out of the four sessions. Despite the physical absence or presence of the foster father, the foster mother's ability to demonstrate her capacity to keep the foster father in mind varied greatly. These dynamics were coded as 3B (FM view of the FF) and 3C (FF view of the FM). For example:

- Mr Morgan was physically absent and was not mentioned by Mrs Morgan until prompted by the therapist;
- Mr Woods was physically absent and was not mentioned by Mrs Woods until Mr Woods played a part in a story about the child;
- Mr Winters was physically present and Mrs Winters made frequent references to Mr Winters, and vice versa;
- Mr Patterson was sometimes physically present, sometimes absent, and was referred to by Mrs Patterson and vice versa;
- Mr Stewart was physically absent but was frequently referred to by Mrs Stewart.

Despite this being a small-scale study, this was particularly significant, as four of the children in this study did not know who their birth father was, and one had been told (untruthfully) that his birth father is dead. All of them at some stage had shared a household with their birth mother's male partner(s), some of whom were known sex offenders.

Although there may be multiple reasons why a foster father would not or could not attend the parent support sessions, the idea of the couple is essential in developing the child's awareness of its own internal world and the internal world of others. Dana Birksted-Breen (1996) suggests that it is the behaviour of the penis-as-link that has a structuring function and promotes mental space and thinking, in that it recognizes the full Oedipal situation, including the parental relationship.

Developments over the four sessions

The following table represents the changes in the overall psychological-mindedness score (PM) after the four sessions. (See also Appendix 2.)

TABLE 8 - Foster carers' 'psychological-mindedness'
in the first and last session

Participant	FM1	FF1	FM2	FF2	FM3	FF3	FM4	FF4	FM5	FF5
PM S1	-6	N/A	31	N/A	96	13	11	41	37	N/A
PM S4	**22**	N/A	**58**	N/A	**90**	**29**	**24**	N/A	**86**	N/A

From this data it can be concluded that even short-term psychoanalytically-informed parent/carer support can bring about a significant improvement in the foster carers' psychological-mindedness in relation to the children in their care.

- **The typical pattern**

Not only had the overall levels of psychological-mindedness increased, there were also significant changes in the ways in which psychological-mindedness was expressed (2E, 2F, 2G, 2H, 2I and 3E, 3F, 3G, 3H, 3I). To demonstrate these changes, here are some examples of the changes that occurred in the families with the lowest and highest overall score of psychological-mindedness (Mrs Morgan (FM1) & Mrs Winters (FM3)). (For details of the other carers, see Appendix 2.)

GRAPH 2 – Changes achieved in foster carers' 'psychological-mindedness' – sub-category analysis

FM 1

A bar chart titled "FM 1" with a vertical axis ranging from -20 to 15 in increments of 5. Categories 2E, 2F, 2G, 2H, 2I are shown along the horizontal axis. Two series are plotted: FM1 S1 (blue) and FM1 S4 (green).

- 2E: FM1 S1 ≈ -14, FM1 S4 ≈ 10
- 2F: FM1 S1 ≈ 11, FM1 S4 ≈ 4
- 2G: FM1 S1 ≈ 12, FM1 S4 ≈ 3
- 2H: FM1 S1 ≈ -9, FM1 S4 ≈ -2
- 2I: FM1 S1 ≈ -6, FM1 S4 ≈ 7

Legend: ■ FM1 S1   ■ FM1 S4
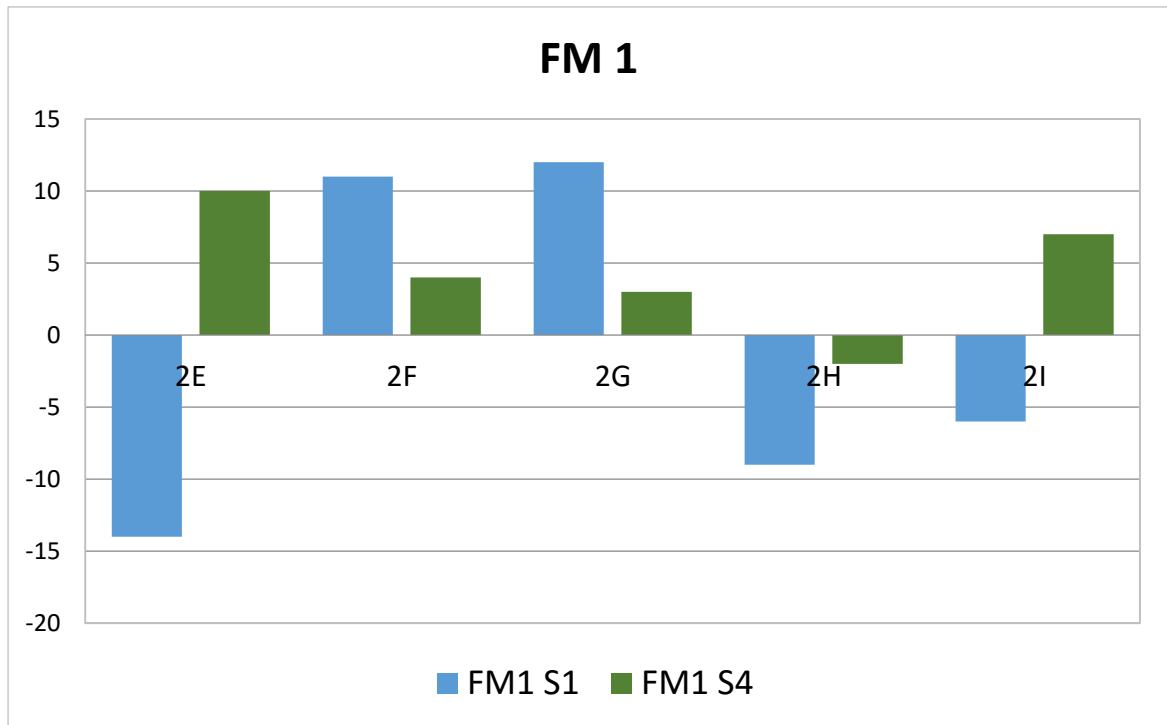
In this example, it is evident that Mrs Morgan's comments that suggest an insight or her empathy regarding Anna have increased significantly (2E); however, her focus on the child's bodily presentation (2F) and her descriptions of the child's affect (2G) have reduced significantly. Instead, more thought is now given to the child's ways of coping (2H) and the impact on Anna of her early experiences (2I).

This suggests a significant shift in the foster mother's thinking about the child, away from focus on the child's behaviours and towards focus on the causes of those behaviours. This in turn suggests that psychoanalytic parent support is particularly important in fostering the relationship between the internal worlds of the foster carer and the child.

- **Deviation from the typical pattern**

GRAPH 3 - Changes achieved in foster carers' 'psychological-mindedness' – sub-category analysis

FM 3

A bar chart titled "FM 3" with a y-axis ranging from 0 to 35 in increments of 5, and an x-axis showing categories 2E, 2F, 2G, 2H, 2I. Two series are shown: FM3 S1 (blue) and FM3 S4 (green).

- 2E: FM3 S1 ≈ 32, FM3 S4 ≈ 31
- 2F: FM3 S1 ≈ 19, FM3 S4 ≈ 13
- 2G: FM3 S1 ≈ 18, FM3 S4 ≈ 15
- 2H: FM3 S1 ≈ 11, FM3 S4 ≈ 12
- 2I: FM3 S1 ≈ 16, FM3 S4 ≈ 19

Legend: ■ FM3 S1 ■ FM3 S4
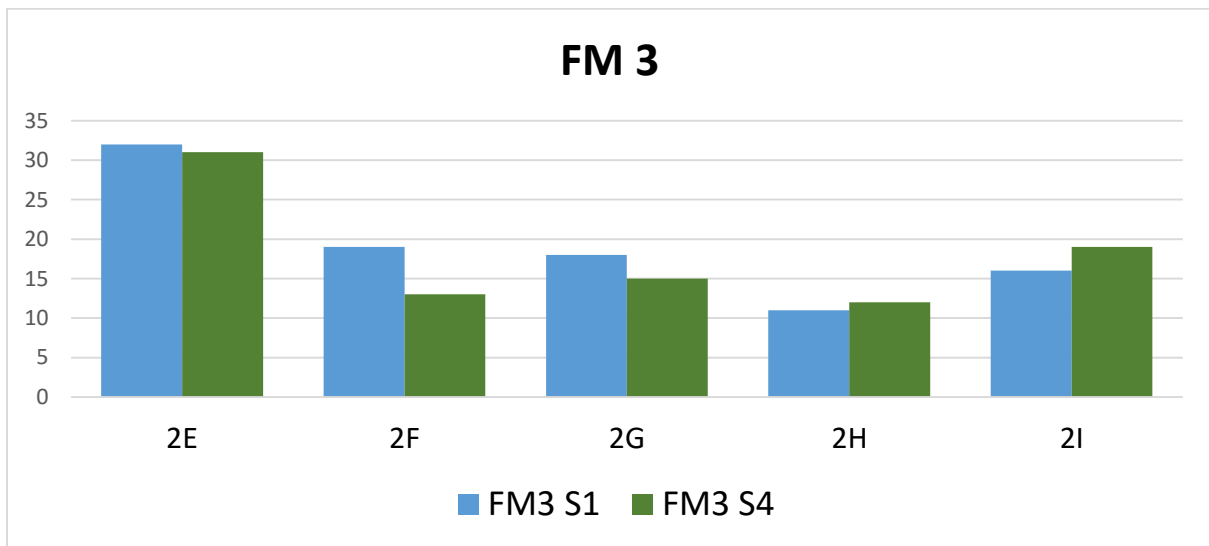
Mrs Winters, by contrast, showed little change in overall psychological-mindedness over the four sessions, in comparison to the rest of the group, but a pattern similar to the others occurs, where the carers become more preoccupied with understanding the reasons behind the child's presentation. Although such minor discrepancies are not unusual, they still seemed meaningful. While for the rest of the carers, including Mr Winters, there was a change indicating increased closeness to the child – i.e., the carer's level of insight and empathy increased – in the case of Mrs Winters a slight distance was created over time. This prompted a further hypothesis**:**

that there is a continuum, or a spectrum, of distance and closeness between the child and the foster carer, which through psychoanalytic parent support work can be regulated, in order to support the carers in coping with the distressing projections of the child and continuing to be psychologically-minded about the child.

Although up until this point the main focus of these findings has been on more quantitative changes, this new hypothesis indicated the need for further qualitative exploration.

The carer's responses to the child's communication of distress or trauma (Coding Stage 5)

To understand this question further, we shall have an in-depth look at the range of responses of each of the carers, as reported during the first parent support session. Some of the responses are employed repeatedly by the carer, indicating that this is possibly a peculiar characteristic of this particular carer.

These examples demonstrate the powerful impact these children's trauma (and its aftermath) has on their carers. They also reveal the correlation between the child's distress and the carer's internal processes. Before listing each carer's responses to the child's distress in the first session, a short introduction will be given to the carer's views on fostering in general, in order to set a context of the carers' expectations or reasons for fostering.

Although what follow are somewhat lengthy lists of the carers' responses, the extended descriptions conveyed the more qualitative and more human quality of the carers' struggles in caring for traumatized children. At a later stage, these raw responses were grouped and categorized.

Mrs & Mr Morgan (F1)

- **Their view on fostering as reported by the carer:**

'Ah well... Me and my husband decided we wouldn't mind having some more children in the house, so we applied for it, for the fostering then, so we did, and I've been doing it for about 14 years now.
(…)
…some of them were short-term, well I am a short-term foster carer, but every time I get children they always stay with me about 3 or 4 years, so they do, you know. Whereas they have asked me to take Anna on permanently now, so they have, you know, until she's 16.
Therapist: And what do you think about that?

Mrs Morgan: I'm OK about it, my husband and I both agreed on it, you know, so we have.

Therapist: That is quite a commitment for you.

Mrs Morgan: It is, it is, aye. But… she seems happy enough with us, now she has told everybody, her social worker has explained to her that because of her mummy's illness she'll not be back with her mummy, so she's staying with us until she's 16 or 18 and then we'll see what happens, whether she wants to go back or not. And she seems to be happy enough with that, because she's telling everybody that she's staying with us until she's 16.' (FM1S5P21)

(At this point, it is important to emphasize that the long lists below represent the carers' responses to the child's distressed and distressing communications only (some of them recurrent), and not the totality of their responses to the child in their care.)

- **Mrs Morgan, Session 1 – raw list of her responses to the child's communication of distress or trauma (in alphabetical order):**

Avoidance of ascribing meaning to the child's actions

Avoidant of difficult affect

Awareness of changes in the child's affect

Awareness of problematic feelings

Awareness of the child's attachment difficulties

Awareness of the child's attachment difficulties is confusing for the carer and is being taken personally

Awareness of the child's developmental stage

Awareness of the link between Anna's visits to her granny and Anna's mood, but followed up by closing down, not exploration

Awareness without links

Being closed to pain creates reactive response of aggression

Carer needs to be claimed by the child

Child's defences are interpreted as 'not understanding'

Child's despair creates feelings of helplessness in the carer, 'there's no point talking to her', using distance as a regulator

Child's longing for the birth family is seen as a problem in the carer's own relationship to the child (one of them must be excluded)

Closing down

Confusion about the care plan, struggling to claim the child

Confusion of roles

Distancing by using Social Services

Distancing from the child's expression of negative feelings by creating a physical distance

Does not offer the child psychological parenting

Does not see the fostering as a process, but more like a task that is or isn't done (right and wrong). This possibly closes her to the exploration of struggles.

Expressing the echo the child's distress creates in the carer

Externalizing difficulties, which is a sort of distancing from the impact this child has on the carer

Feeling attacked by the child

Focus on management rather than understanding: this is expressed by addressing the physical content, such as medical or hygiene needs

Giving up on the child, losing perspective

Good observation, no link

Good observation, no link to separation difficulties

Identifying with the rejected child

In identification with the child

Insight

Insight

Lacking awareness of the child's developmental needs

Lacking psychological parenting

Linking behaviour to narrative

Links with the birth family/the past seen as problematic

Losing sight of the child's attachment to her

Making a link to past experience, but only on a superficial level

Minimizing the child's difficult feelings and taking these responses personally ('cheeky')

Misinterpretation of the child's defences as a personal attack

Needs to be claimed by the child

No meaning ascribed to the child's actions

No meaning ascribed to the child's actions

No meaning ascribed to the child's actions

'Odd thing' – disapprovingly communicating the difference between the child and self

Out of touch with the child

Possibly also communicating her worry that she will be forgotten by the child

Projection

Regulating by distancing

Reluctance to explore the child's inner struggles

Relying on the child

Resentment of commitment to this child? It is as if saying, 'why do you always need to be so difficult?' and not naming that being a foster carer is a difficult task

Resorting to behaviour management

Rivalry with the birth mother

Rivalry with the birth mother

Seems to be reassuring the therapist that she is doing a good job and that the child thinks that too

The carer finds it difficult to acknowledge the birth mother's significance

The carer has some awareness, but seems to struggle to bear the child's feeling of loss; the carer seems to feel undermined by the child's longing for her birth mother

The carer is making an observation but is not linking this to the child trying to cope

The carer is making an observation but is not linking this to the child trying to cope

The carer is making an observation, but no links made to the child's way of coping

The carer is recognizing that the child's way of coping is not age appropriate

The carer seems to be misinterpreting the child's responses (ways of coping)

The carer seems to struggle to assume responsibility for psychological parenting of the child

The carer struggles to see why the child would seek her company – distancing

The carer takes the child's longing for her birth mother personally and yet idealizes the birth family

The carer's lack of confidence to be an effective carer for this child is communicated back to the child, and as a result there is a regression in the adult/child relationship

The child's loyalty towards the birth mother is defended against

The difficult feelings in the child are interpreted as personal attacks, and the reactive response is the carer's 'temper'

The foster carer is struggling to see her role as psychological parent of the child

The phrase 'type of thing' is used to substitute for her own difficult feelings about the child's presentation

The use of language implies confusion about the care plan

Transference – the carer is ambivalent about being offered support

Use of the word 'boss', implying a power struggle

Using Social Services to perform the role of psychological parenting

In this particular example, the foster mother describes herself as a short-term carer who has now, for the first time, taken on a child in a long-term placement. This raises the question, whether there is a difference between the carer's focus in relation to the child care in a short-term or in a long-term placement. Could some of her task-oriented rather than attachment-led responses, or her tendency to distance herself from the psychological parenting of the child, be explained by the painful process of separation at the end of each previous placement, over the fourteen years of her fostering experience?

If this were found to be the case, it would suggest the necessity of providing additional, specialized support for carers who decide to take on a long-term commitment to the child, giving due consideration to the child's future trajectory, developmental stages, care plan, and the development of long-term attachment, where long-term psychological parenting can be provided for the child by the carer. This also opens up the possibility that not every good-enough carer will be suited to providing a long-term placement.

In accordance with the methodology of Grounded Theory, the initial categories emerging from an analysis of the first family were applied to the analysis of subsequent families, while the individuality of carers' responses necessitated the creation of new categories.

Mrs & Mr Woods (F2)

- **Their views on fostering as reported by the carer**

'When she goes, you would be glad to get a wee break, so as I can go out and see my friends and that, but when she's away there's that big emptiness in the house, you do miss her.' (FM2S1P28)

'I worked in school (…), it was a few years back, there were children in and they were from overseas, so they were, and they had been fostered out and then they had been moved on, and I always thought about them, so I did. Then sort of, my own children were getting up and I didn't have any grandchildren at this stage, and that's when I applied for it. I used to sit at Christmas time and would think there's some wee child out there, you know, you always think of…, and then... I applied for it ...and then everybody came at once. My granddaughter came along, and then her brother and then Madison and so they all came together, I think Madison was there about two weeks before my granddaughter was born.' (FM2S1P34)

'Therapist: How much do you know about her background, her early background?
Mrs Woods: Very, very little of her background. Just that before she came to me, she went to, I think. It was two other carers, just for a short time, a week or two.' (FM2S1P50)

'Therapist: And how is she with your husband?
Mrs Woods: She's great. When she first came she just, she loved him, 'cos she had no father figure in the house. She was very, very attached to him, so she was, but she gets on well with him, so she does. Now he doesn't do any cooking or anything, but he would, you know, he would have great patience with her, so he would. He's like that with the grandchildren, so he is.
Therapist: Would they do things together?
Mrs Woods: No, not necessarily, you know, just maybe reading or, you know, homework or things. Nothing...he's out with his pigeons constant... he doesn't even do things with me… (she laughs) *so he doesn't.'* (FM2S1P173)

- **Mrs Woods, Session 1 – raw list of her responses to the child's communication of distress or trauma**

Attuning to the child's wishes

Awareness

Awareness

Awareness of being different from the birth mother

Awareness that the child's behaviours are unusual

Carer demonstrates awareness of how the child relates to her objects

Carer does not want to think about the child's destructiveness

Carer intentionally avoids verbal communication

Carer is linking the child's distress to the absence (presence) of significant attachment figures – carer is taking the position of the left-out third

Carer is making insightful observations, but struggles to verbalize this for the child

Carer is struggling to think

Child communicates via projections and carer becomes overwhelmed

Child's experiences are denied

Child's second-skin defences serve the purpose of distraction from the carer's own internal world

Denial of the child's traumatic past experiences

Denial of the child's disturbance (the child's distress and her aggressive response of not being heard)

Denial of the child's murderous feelings towards vulnerable creatures

Denial of the child's rougher feelings

Denial of the negative

Focus on the child's behaviour rather than the reasons for it

Heightened level of affect by the child produces insistent instructions by the carer – feeling stuck

Idealizing the child's experience of the birth mother

Idealizing the child's relationship with the birth mother

Identification with the birth mother

Minimizes the child's aggressive behaviour

No consideration given to triggers or context – feeling stuck

No meaning ascribed to the child's actions

Not dealing with the emotional content of the child's worries – denial

Offering incentives and threats to resist distressed and distressing behaviour

Overwhelmed

Overwhelmed by the child's communication of distress

Potentially creating a situation where the child holds herself responsible for the damage

Social Services providing a more realistic view of the contact with the birth mother – effective third perspective

Struggles to hear the therapist naming the negative

Struggles to hear the therapist naming the negative feelings in the child

Struggles to name how hard it is to cope for this child – distancing from the reality of her own experiences (the carer uses the word 'you' when it is actually 'I')

Struggles to notice the significance of the child's unboundaried chatting

The carer feels easily undermined in her capacity as a parent

Turning a blind eye to the child's rougher feelings

Turning a blind eye to the child's rougher feelings

Under the pressure of the child's projections

Using the child's birth family to distance herself from the child's projections

This carer is a particularly interesting example, because my overall impression of her was one of a caring and loving foster mother, who always seemed to attend well to the child's physical and educational needs, and who tended to interpret the child's behaviour in a positive light. Although there was some sense of this foster mother feeling somewhat isolated in her own life, only with closer analysis of her responses to the child's distressed and traumatic behaviour did it become evident that the carer's difficulty in staying with and bearing the child's rougher and destructive feelings is problematic in the care situation.

In fact, although it can be a delicate matter in the context of parent support work, it is worth considering whether there is a possibility that this carer's own unacknowledged emotional needs prevent the child's emotional needs from being recognized and attended to.

Mrs & Mr Winters (F3)

- **Their views on fostering as reported by the carers**

Mr Winters:

'My daddy died when I was 8, you know, and I used to go to school and I would hear boys saying, "my dad this and my dad that", and I used to think to myself, "they're lucky to have a dad", you know that way.' (FF3S2P100)

'I can actually remember sitting in front of the television, and I can remember the advertisement and I think we shed a tear each, cause there was something about a child or something like that, and I think that just made us go for it. You know?' (FF3S2P120)

Mrs Winters:

'Em, well we have no children together. I have a daughter by my first husband and then that was one of the main reasons we thought we would...' (FM3S2P98)

'I had a big family and I had a wonderful childhood. You know, there was only me and my sister, but my parents were, you know, they gave us everything, you know. They gave us love and affection, and, you know, we had such a happy home.' (FM3S2P113)

'…we wanted to give something back, we wanted to do something for somebody else, didn't we …' (FM3S2P111)

'… the reason we went long term is, because, you see, they were up for adoption and they couldn't find anybody and em… and it drifted and drifted (…) because they don't read well on paper, they turned them down every time. And I thought to myself no, no I'm keeping them, I'm not letting this happen.' (FM3S2P123 -126)

- **Mrs & Mr Winters, Session 1 – raw list of their responses to the child's communication of distress or trauma:**

Mrs Winters, Session 1

Able to identify ordinary challenges in the child's behaviour and overcome them

Acknowledgement of the input of others

Assuming parental responsibility for the child's physical wellbeing

Assuming parental responsibility in a psychological sense

Attempting to understand the traumatic communication

Attempting to piece together the child's narrative

Attempting to regulate the child's affect

Awareness

Awareness of the child's developmental stage and defences

Awareness of the child's emotional responses, and attempting to give the child an alternative view, but I wonder about this being an opportunity to reintegrate the incoherent memory instead

Awareness of communication of distress via the body

Awareness of developmental deficits

Awareness of early deficits and the child's needs

Mr Winters, Session 1

Avoidance of thinking about the child's communication of trauma

Awareness

Awareness of the child's developmental stage

Good observation, but no emotional meaning is attributed to the child's behaviour – resorts to behaviour management

Identification with the child

Interested in the reasons behind the child's behaviours

Observation of the child's defences

Observation of the child's way of coping, but not realizing that this may be unconscious

Observation, but no links made to the emotional content of the child's behaviour

Struggling to recognize the child's emotional state

The carer is attuned to the child's needs and is able to project into the child's future

Awareness of neglect while in the birth mother's care

Awareness of the child's internal dynamics

Awareness of the child's internal world, fragility of defences, and how the child perceives and relates to his objects

Aware of and attuned to the child's internal dynamics, but mentions no impact the boy's actions had on her or on her other son

Consideration given to the child's past experiences

Contextual thinking, able to attribute emotional reasons for the child's behaviour

Differentiation in the levels of distress

Does not name in words the shocking effect this experience had on her

Emotional meaning given to the physical manifestation

Expressing concerns for the child's social development

Functioning as a parent, by helping the child to overcome the resistance retriggered by frightening memories

Insightful observation

In touch with the child's affect, concern for the child's defences – emotionally attuned parental concern

In touch with the impact of trauma on the child

Liaising with professionals, making links, seeking a coherent approach

Making sense of trauma

No mention of her own feelings

No mention of what it is like to hear the child's recall of violence

Not naming her own experience

Observation of the child's way of coping, but not realizing that this may be unconscious

Own experience of the child is not named

Perseverance in attempting to change the child's self-reliant coping mechanisms

Possibly feeling guilty for wanting respite

Possibly feeling guilty for wanting respite

Seeking the help of professionals

Seeking specialist help

Sharing information with other professionals – making links

Trying to put words on the child's internal dynamics

Wanting to understand and prepared to seek supports

Wishing to understand the child's distress, awareness of internal dynamics in the child

This example demonstrates the significant difference between the foster mother's and the foster father's responses to the child's distress, confirming the earlier claim about the importance of the capacity of the individual carer to metabolize the traumatic communication presented by the child. This once more emphasizes the importance of considering the impact of each of the foster parents where a child is cared for by a couple.

Furthermore, a new dynamic emerges here, especially in the foster mother's responses, which indicate a significant focus on the child's needs and the assumption of parental responsibility for the child's wellbeing, alongside a real difficulty in naming the impact that the child's traumatizing communication of trauma and distress has on the carer. This raises an important question about the carer's understanding of their role as a foster parent.

Is it possible that a certain level of identification with the child's experience and needs can create a sense of responsibility, not only for the child's future well being, but also regarding the child's traumatic past? Would it be appropriate to consider the impact that guilt and consequent altruistic defences might have on the ways in which the child is cared for? If so, the earlier assumption about the role of the child psychotherapist in supporting carers in assuming the role of foster parent becomes an essential component of support for the placement.

Mrs & Mr Patterson (F4)

- **Their views on fostering as reported by the carers**

'Mrs Patterson: I got him when he was six. And I said to them, "Wait till I tell you, there's just something not right with this child, I know there's just something. I don't know what it is because I'm not a professional, but I'm a mother and there's just something not right". And I've said to them all through the years, there's something not right. And then they did the wee book with them [Kevin and his sister] *for their family and all, and they didn't even finish it right. And I had to go back and say, "look I want this finished, because this child's in a limbo of a baby in a hospital … and he doesn't know what's happened between there and me." So they, sort of, did finish it and they've had about maybe six or seven social workers in the years.'* (F4S1P77)

'Mrs Patterson: You sent a child to school at nine o'clock in the morning and then that child is in a different house at half past four in the afternoon, to strangers, you know what I mean. It wasn't ever explained to them.' (F4S1P184)

There was no comment made by the foster father other than to say that he himself had had an experience of being in care.

- **Mrs & Mr Patterson, Session 1 – raw list of their responses to the child's communication of distress or trauma:**

Mrs Patterson, Session 1	Mr Patterson, Session 1
Avoidance of psychological parenting	Awareness of the child's internal dynamics
Avoidance of psychological parenting	
	Denial of the child's trauma
Avoidance of psychological parenting: the foster mother seems to feel that her capacity to parent is lost	Feeling persecuted

Awareness of dynamics in the child's internal world	Feeling persecuted by the child's actions
Awareness of her own limitations in supporting the child	Insight
Awareness of the impact of the trauma	Insight
Awareness of the need to regulate the level of affect	Insight
Awareness of the transference	Insight
Awareness of the transference, attributing this to an oversight by Social Services	Lacking awareness of the child's internal dynamics
	Lacking insight
Awareness of trauma	Misinterpreting the child's communication
Awareness of unusual presentation of the child, but the carer makes no link to the child's past experiences	No psychological parenting of the child
	Observation, no link
Child's actions are misunderstood	Observation, no link
Denial	Observation, no link
Distancing	
Distancing	
Distancing from psychological parenting	
Feeling helpless	
Feeling helpless and unsupported	
Feeling paralysed	
Feeling persecuted	
In projective identification with the child	

Insight

Interpreting the child's attachment difficulties as persecutory

Lacking insight

Lacking insight

Naming the child's impact on the carer

No meaning attributed to the child's actions

No meaning attributed to the child's actions

No meaning attributed to the child's actions

Not verbalizing the impact on the carer

Once her own struggles were named, the foster mother was able to recognize the child's constructiveness

Out of touch with the child's developmental stage

Overwhelmed

Overwhelmed

Seeking support

Struggling to process the child's actions

Struggling to process the child's behaviour – paralysed

The carer seems repelled by the child's action and seems unable to process the difficulties presented by the child

The child's communication of distress is correctly perceived as distress

The child's developmental stage is not recognized as part of the ordinary presentation of an emerging adolescent

The foster mother feels victimized by the child's behaviour

The foster mother has observed the child's difficulties with transitions, but makes no links

The foster mother seems unable to process the child's communication of distress

The meaning of the child's action is misunderstood

Once again there is a notable difference between the foster mother's and the foster father's responses. **Also, it is evident that even though both carers can recognize the child's distressed and distressing communication as stemming from traumatic early experience, the foster mother's responses suggest that there is a difference between the carers knowing and their being able to actualize this knowledge; once again pointing to the role of the psychotherapist in helping the carer to distinguish between the carer's own traumatic response and that of the child.**

Mrs & Mr Stewart (F5)

- **Their views on fostering as reported by the carer**

'…I said to social services that that's okay, he can come and live with us. Although, he's not exactly the child they told me he was. But they never do.' (FM5S1P36)

'Mrs Stewart: Foster carers are different people and some are quite laid back or very strict or middle of the road. And for me, I said to myself when he first come, we are going to be just a little bit above the middle. So we are not at the extreme of being strict, but we just want to be a little bit above the middle so that he knows that I'm the adult in the house. I explain this to the children when they come anyway. The house is full of fun, but we need to remember that there is a crowd of us living here and we have to respect each other and sometimes I will have to say that it will have to be quieter or not so aggressive, or a little calmer. So I started off, and I'm pretty happy I started the way it went, because it seems to be what suits him very well.' (FM5S1P40)

'I didn't attend grammar school, I went to high school, but the rest, I mean my husband and my family, they went to the grammar schools. And for a few of the foster children that I have worked with as well I've really seen their potential, so I've been very driven and they've been willing to work. I've explained to them the educational system, maybe they're not aware of it, some of them aren't aware that when you get to an age you have a choice, you have a choice of all the schools and it can be your choice as a small individual where you want to go.' (FM5S1P58)

'You just have to look to the future and hope that someday you will make a difference. But sometimes you don't see that difference for a very long period anyway and it even could be, because for even some of my little children who have left, you don't see it until after they've gone. (…) But it's not just about what you instil in them, it's them watching your other children as well, how they respond to what you're instructing them to do. The other children, the foster children, they quite

often, not immediately, it takes them a long time you know to adjust to this family life.' (FM5S1P54)

- **Mrs Stewart, Session 1 – raw list of her responses to the child's communication of distress or trauma:**

Able to name things that the carer finds difficult about the child

Able to overcome the child's resistance

Able to regulate the child's affect

Assuming parental responsibility

Assuming responsibility for psychological parenting of the child

Assuming responsibility for psychological parenting of the child

Awareness

Awareness of the child's affect

Awareness of the child's developmental deficits

Awareness of the child's developmental deficits

Awareness of the child's developmental deficits

Awareness of the child's developmental needs

Awareness of the child's developmental needs

Awareness of the child's bodily expression

Distancing from her own supports

Feeling stuck

Not verbalizing the impact of the child on herself

Persevering to overcome the child's defences

Persevering to overcome the child's defences

Persevering to overcome the child's defences

Prioritizing the child's needs over her own

Projecting

Recognizing the child's defences

Struggling to verbalize the child's impact on herself

Taking responsibility for the psychological parenting of the child

Wishful thinking

Wishful thinking on behalf of the child

In the case of this carer, the carer's responses are largely focused on overcoming obstacles. In this first session, the foster mother's conscientious approach seems to be more cognitively determined, rather than permitting emotion-led responses in the child. This is largely related to the fact that Cameron, owing to his autistic traits, evoked in the carer significant self-agency for action to overcome the child's defences.

The above examples provide strong evidence that the child's trauma-driven communications trigger transference responses in their carers. The carer's own childhood experiences are triggered by the child in their care and are then repeated, rather than remembered, in the carer's transference to the child.

Sigmund Freud (1914), in his paper 'Remembering, repeating, and working through', wrote:

'*The patient does not* remember *anything of what he has forgotten and repressed, but* acts it out. *He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating it.*' (Freud, 1914: 150)

Unfortunately, this being a short-duration project, there was not sufficient opportunity to explore the carers' own childhood experiences, other than the few that were spontaneously shared in the course of the support sessions. Moreover, whereas some carers seemed to share those memories fairly readily, others were reluctant to explore their own childhood, insisting that they were 'here to talk about the child'.

Further refinement of the responses in foster carers to the child's communication of distress and the compulsion to repeat (Coding Stage 6)

The attitudes and concepts attributed to foster carers in the sections above serve to increase our understanding of the kinds of difficulties that foster carers face when caring for a traumatized child. It becomes clear from the analysis of this data that, one way or another, each of these carers frequently identifies, in their own individual way, with the child's pain. And the emotional experience of witnessing the enactment of a child's compulsion to repeat early trauma can at times trigger echoes from the carer's own past. Alan Shore (2012) goes so far as to suggest that these trauma-driven communications actively seek to spark similar responses in others: right brain to right brain communication. There are times when the child's powerful feelings are strongly felt by the carer, whose own responses are adequately regulated so that they can remain psychologically minded. At other times, the carer's psychological equilibrium is rocked and becomes impaired, or insecure. Or in some cases, the carer fully identifies with the child's pain. In these latter situations, facing up to the child's distressed and distressing communication becomes so unbearable for the carer that she or he has to turn away from the reality of that pain. Hamish Canham (2004) comments on his clinical experience of what it is like to be on the receiving end of such communications:

> *'Deprived and abused children bring to the therapy a set of experiences and feelings that are often of a truly terrifying nature. ... When these experiences begin to enter into the transference they can lead to a complicated set of*

feelings in the therapist: a desire to protect oneself and not hear, to protect the room, to fight back when under attack, overwhelming states of rage, sadness and despair.' (Canham, 2004: 145)

The term '*identification'* has been used in a great variety of ways in the psychoanalytic literature, from Freud on, and it continues to be used in countless consulting rooms on a daily basis, without ever being very tightly defined. It is often compared to, and defined in terms of, various other psychoanalytic concepts, such as imitation, incorporation, introjection/projection, and internalization/externalization (Meissner, 1970, 1971, 1972). However, following the broad lead of Freud, the term 'identification' is being used in this study to refer to the various ways in which a foster carer, by (largely unconsciously) using the mechanism of empathy, 'feels into' the affective experience of a traumatized child in his or her foster care, in a particular situation. Freud summarizes the phenomenon as follows:

'A path leads from identification by way of imitation to empathy, that is, to the comprehension of the mechanism by means of which we are enabled to take up any attitude at all towards another mental life.' (Freud 1921: 110)

According to the findings of this study, depending on the influence of the carer's own early experiences, carers tend to respond to the distressed child in their care in one of the following ways:

- Carers identify with the child and distance themselves
- Carers identify with and merge with the child
- Carers identify with the child and switch between merging and distancing
- The carer's psychic equilibrium is impaired
- The carer can offer 'good enough' psychological parenting.

We shall now briefly consider each 'parenting' stance in turn.

- **Carers identify with the child and distance themselves**

When painful echoes of the child's distressed communication awaken primitive early anxieties of annihilation, the carer may become unable to deflect the destructiveness of the death instinct (however understood) from within, and this in turn triggers the carer's early primitive defences. As a result, the carers either: expel the unvented emotional states that are stirred up by the child's communication of distress by means of projection (including projective identification) and envy (an attack on the good object); or turn to denial of their own internal responses to the child's communication and external reality; or take flight to the idealized good object; or use the mechanism of splitting. Thus, part of the carer's ego turns away from the reality of the child's pain, since that pain gives rise to unbearable anxiety in the carer:

> '… when parents are themselves traumatized they become preoccupied and less able to help the child process intense sensory and affective experiences, leaving the child prone to anxiety and to experiencing some imaginative ideas with the intensity of feeling that might be expected had they been real.' (Target & Fonagy, 1996: 459)

- **Carers identify with and merge with the child**

The experience of being confronted by the child's distress might generate great anger and aggression towards the child, who has impaired the carer's equilibrium and capacity to parent. For Melanie Klein, defence mechanisms (laid down in infancy) are primarily activated against anxiety and guilt towards the object: thus, defence mechanisms defend against one's own angry, or even murderous, impulses. In an attempt to 'undo' the presumed damage of the anger generated by the child's distress, the carer suddenly becomes in touch with the child's powerful affect, at times '*devoting oneself entirely*' to the child, but to an extent that there is no longer any freedom to think about the gravity of the situation, so lost is the adult in the pain of the child: so that, for example, the carer can no longer recognize her own urgent need for respite. (Hinshelwood, 1994: 89)

In an alternative understanding of this phenomenon, Anna Freud (1985) highlights the defensive aspect of altruism:

'There are two purposes served by this defensive process. The subject can "take a friendly interest" in the gratification of the people's drives, and thus indirectly gratify his own. It also frees the activity and aggression associated with the fulfilment of instinctual wishes, so that these can be used on behalf of others.' (Sandler & Freud, 1985**:** 427)

- **Carers identify with the child and switch between merging and distancing**

In some cases, the carer switches between merging and distancing in ways that are completely unpredictable for the child, often replicating by identification the child's early care experience. This response is likely to put considerable strain on the stability of the placement. Anna Freud writes about this in terms of identification with the aggressor, as a means of coping with the anxiety:

'Children or adults introject characteristics of the anxiety-provoking object or the aggressor and thereby attempt to assimilate the experience of panic and helplessness to which they have been subject.' (A. Freud, 1936: 113)

- **The carer's psychic equilibrium is impaired**

In the relationship between foster carer and traumatized foster child, the dynamic interplay between distress, anxieties and defences is always seeking expression, but the carer's responses are not always defensive. This depends on the carer's capacity to bear the anxiety produced by the child's presentation, both the distressing quality of it and the frequency of its occurrence. In these situations, it is possible that the carer can remain merely somewhat impaired, or shaken, by the force of the child's distress, rather than experiencing it as a lethal threat to their ego integrity. Anna Freud, in her dialogue with Joseph Sandler, describes a kind of denial as a precursor of defence, where the individual simply withdraws her attention from something unpleasant or threatening. (Sandler & Freud, 1985: 340)

- **The carer can offer 'good enough' psychological parenting**

Although Winnicott's theory of '*holding'* implies that mother and baby form a unit, and Bion's (1962) theory of '*container-contained*' implies the baby's ability to recognize separateness, they do seem to have real similarities when describing maternal function: for Winnicott, this requires mother's '*imaginative elaboration'*, while for Bion the appropriate maternal stance is '*reverie'*. Providing the carer's own internal world is robust enough to withstand the child's '*nameless dread*' without a rupture of their own 'being', then 'good enough' psychological parenting can take place.

According to Winnicott, good maternal care can be summarized in his central concept of 'holding', understood both physically and metaphorically. The mother's 'holding' sustains continuity between the moment-to-moment changes in her baby's states of being; and baby depends on mother's identification with her baby, which Winnicott refers to as 'projective identification' (the term here used differently from Klein). (Caldwell & Joyce, 2011: 150)

The above range of carer responses encompasses the various dimensions of psychological-mindedness that underlie foster carers' responses to the traumatic states and distressed feelings of the traumatized children in their care. The various responses illustrate how the impact of the child's past experiences, which are being relived in the present, is metabolized by some carers and not by others; and by some carers some of the time but not all of the time. When the 'good enough' Winnicottian carer is providing their distressed child with a 'holding environment', they are in fact (intuitively and unconsciously) 'containing' and detoxifying their child's terrified projections (as outlined by Bion).

It is also worth considering that, at times, and especially where severely traumatized children are concerned, it takes more than one carer to make parenting 'good enough'. The role of foster fathers (or an alternative 'third') and other family members is often underplayed when considering fostering placements. By illustrating, categorizing and analysing the main differences in foster carers of traumatized children, this research endeavours to contribute to our understanding of long-term fostering, and of how these various responses may provide information and insights that will be of value to the wider systems working with the foster families.

Summary of the findings

The table below provides a summary of the impact the dynamics analysed above have on each party in a fostering arrangement. The table includes the impact of these dynamics (traumatized child/foster carers) on the wider system, but owing to the limitations of this study, this finding could not be adequately tested in the data and it is here presented as a set of hypotheses for further research.

TABLE 9 - The impact of the child's trauma on the care provided

Responses of the carer	Child's emotional needs	Carer's emotional needs	Psychological parenting	Relationships with the system (item for future research)
'Good enough' parenting	Met	Met	Awareness of the interplay between the child's internal and external worlds	Good and reliable communication
'Identifying and distancing'	Mostly neglected	Mostly over-compensated	Carer's emphasis on tasks at the expense of feelings	Over-compensated by the system
'Identifying and merging'	Mostly over-compensated	Mostly neglected	Carer's emphasis on feelings at the expense of the real world or others in it	Ambivalent commitment by the system (e.g., frequent changes in social workers)
Carer's equilibrium 'impaired'	Mostly met	Mostly met	Impaired	Carer can be either seeking support or distancing from the system

It is important to bear in mind that the carers in this study have all been deemed by Social Services to be fit to provide adequate care for the children in their care. Also, the four categories above have been applied only to the situations that the carers found the most challenging, and not to the carers' overall responses to the child, which might well paint a different, perhaps more hopeful picture. However, this categorization is significant in pointing up the fact that it is not helpful to take an overall blanket approach in either selecting foster carers or in preparing a person to become a foster carer; and furthermore, that the preparation required to produce a good long-term foster placement is not only about preparing the child. On the contrary, in order to provide a 'good enough' long-term parenting experience for a traumatized child, one must become familiar with one's own responses to distress, or at least consider the fact that they play a significant role in how one responds to the child overall, so that external resources can be called upon if and when necessary.

It is too idealistic to hope that every foster carer would, at some time in their fostering career, consider undertaking some therapeutic self-discovery work themselves. Even those attending parent support sessions are often reluctant (for various reasons) to discuss openly their own negative and difficult-to-bear responses to the child in their care. However, an experienced psychoanalytic psychotherapist can reasonably accurately identify the attunement level of a carer and support them in achieving a more balanced view of the child in their care; and, as is evident from the data in this study, the most effective parent support work is not always about helping the carer to a closer alignment with the child's affect, but in fact the opposite: i.e., it is often just as necessary to help the carer to gain sufficient distance from the force of the child's affect in order to become a more effective parent.

The graph below represents the overall changes achieved over four sessions of parent support work in relation to carers' responses to the child's communication of distress: examples of 'identification and merging' had decreased from a score of 20 to 4; examples of 'identification and distancing' had decreased from a score of 81 to 30; and examples of 'good enough parenting' had increased from a score of 113 to 128. The graph clearly demonstrates that even within the short space of four sessions of weekly psychoanalytic parent work, it is possible to achieve significant change in carers' capacity to bear the child's compulsion to repeat early traumas, and to help the

carers become more available to provide the child with effective psychological parenting at these difficult times.

GRAPH 4

Overall changes in carer's responses over four sessions
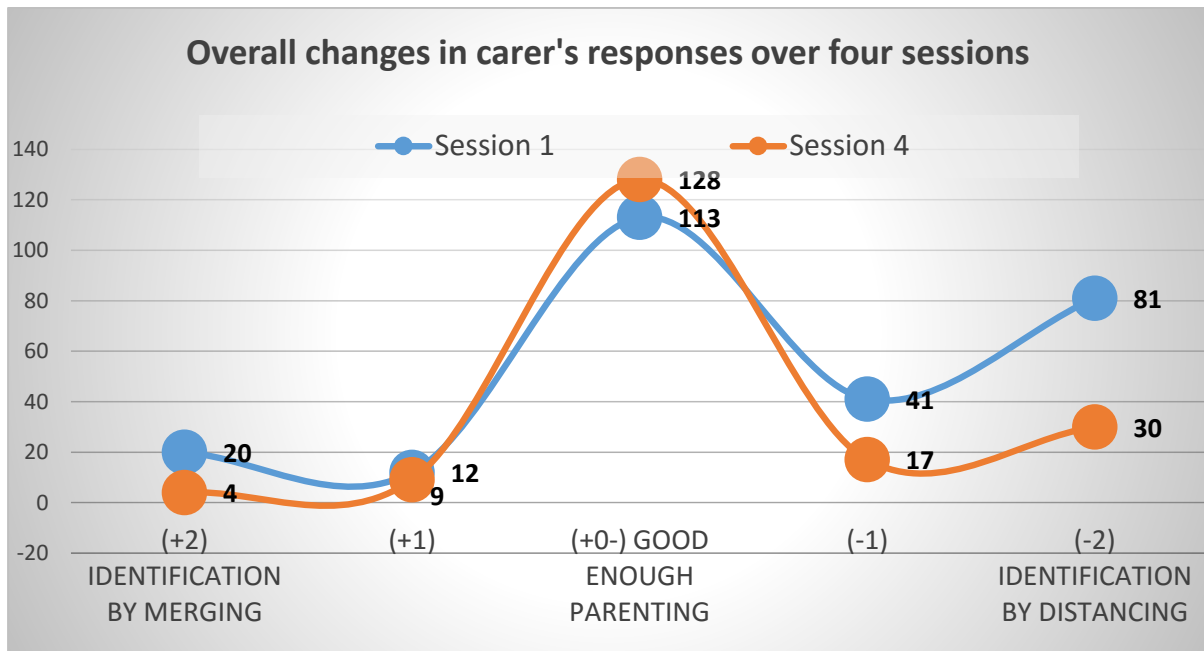
Chapter 9: Recommendations for Further Research

Recommendations for Further Research

The material gathered for this research project generated a great number of curiosities that unfortunately could not be pursued further within the constraints of this limited study. Examples of this include: carers' views about the child's contact with its birth family; or the impact that changes of social worker (sometimes quite frequent) had on the child, the foster carers, and the placement in general. The material also threw up interesting uses of language in response to something that the child did or said: for example, the uses of the word 'boss' when describing child-parent relational dynamics; or the use of the expression 'out of the blue' and its relation to the carer's understanding of the child's internal world. The data also highlighted the need for carers to have specific support in thinking about emotionally-loaded special occasions or anniversaries, such as birthdays or Christmas.

However, upon further study of the findings one particular hypothesis emerged in relation to the carers' responses to the child's compulsion to repeat distressing experiences from earlier in their life. This became clear when the carers' responses were sorted according to the particular sub-category of psychological-mindedness identified in the last chapter: i.e., relating to insight, bodily communication, affect, defences and background narrative. This tabulation highlighted that for some carers a particular sub-category was significantly under-represented (see example below under 2F), or the child's distress evoked particularly strong defensive responses (2G), indicating either a lack of understanding or particular sensitivity in this area. The difficulty in pursuing this line of thinking within the present study lay in the possibility that there are more than the five identified sub-categories, in which case new open coding of the data would be required. However, here is the example of Mrs Woods.

TABLE 10 – Carers' responses in relation to sub-categories of psychological-mindedness

2E Insight/ empathy	2F Bodily communication	2G Affect	2H Defences	2I Coherence of narrative
Denying Fragmentation Identification Denial Seeking support Attunement Awareness Identification Overwhelmed Overwhelmed	No meaning ascribed to the child's actions No meaning ascribed to the child's actions	Avoidance Avoidance Avoidance Becoming overwhelmed Denial Denial Denial No linking No meaning ascribed to the child's actions Avoiding psychological parenting Denial Denial Denial Avoidance	Awareness Awareness Projecting Denial Denial	Denying Distancing Distancing Idealizing Identification Identification by distancing Reliance on the system Awareness Awareness Awareness

Detailed carer profiles such as the above, which clearly outlines an individual's relative strengths and weaknesses, could provide a most helpful indicator with respect to how the parent support could most fruitfully be targeted. Furthermore, the comparison of outcomes of the first and last sessions suggests that, although for some of the carers improvement (learning) may follow a consistent pattern over all areas, for others the pattern of change and development may vary with respect to different aspects of psychological-mindedness. Here are three examples to illustrate this diversity.

Mrs Winters (FM3) demonstrated consistency across the board: i.e., the 'good enough' responses (0 on the horizontal axis) are predominant regardless of the domain of Tony's distress. These graphs also show consistency in the fact that, should Mrs

Winters' capacity to manage Tony's distress be diminished, she is likely to take the child's side at the expense of her own needs (+2).

GRAPHS 5 & 6 – Change in psychological parenting according to sub-categories of psychological-mindedness
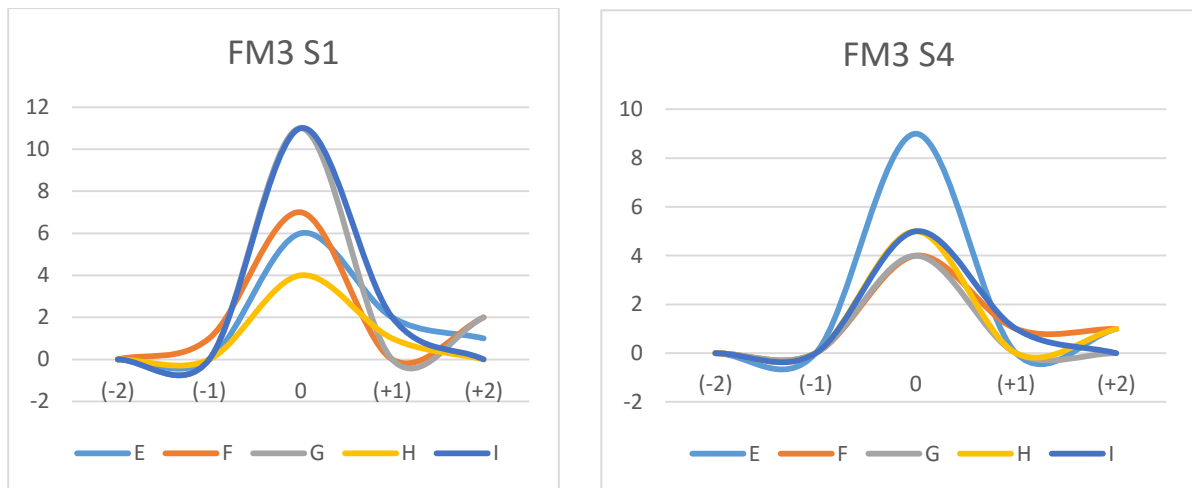
From Mrs Morgan's graphs (FM1) below, it is evident that for this carer, responses to the child's affect ('G' – grey line) are the most responsive to change, whereas seeing things from the child's point of view ('E' – the light blue), especially where Anna's past experiences ('I' – dark blue) are concerned, seems harder to shift.

GRAPHS 7 & 8 - Change in psychological parenting according to sub-categories of psychological-mindedness
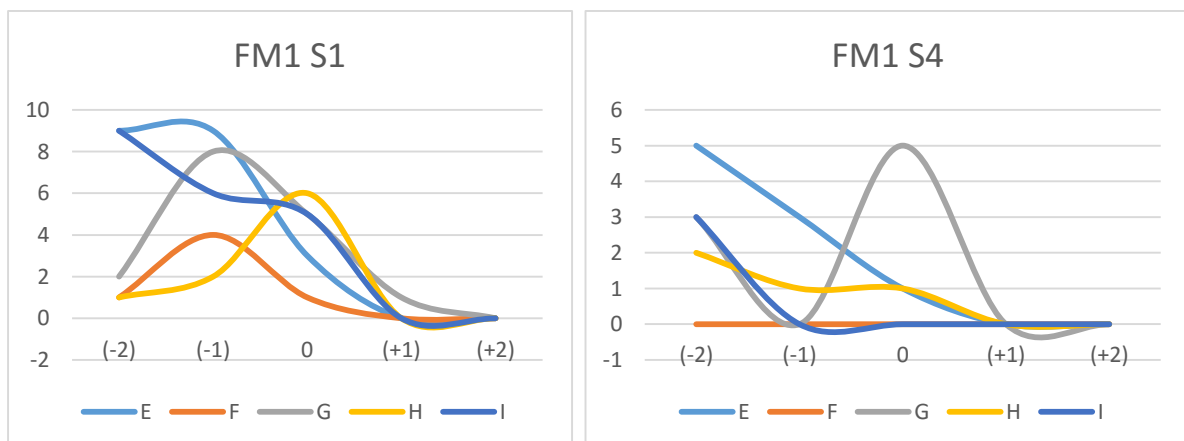
Mrs Wood (FM2), on other hand (graphs 9 & 10 below), shows responsiveness in thinking about the child's compulsion to repeat and increased ability to provide good enough psychological parenting (0) at these difficult times. However, it is evident that responding to the child's emotional states ('G' – the grey line) and showing empathy ('E' – the light blue line) seems easier for her than thinking about the child's narrative and birth family ('I' – the dark blue line). There might also be a possible correlation between these various responses, but unfortunately this was beyond the scope of this particular study.

GRAPHS 9 & 10 - Change in psychological parenting according to sub-categories of psychological-mindedness
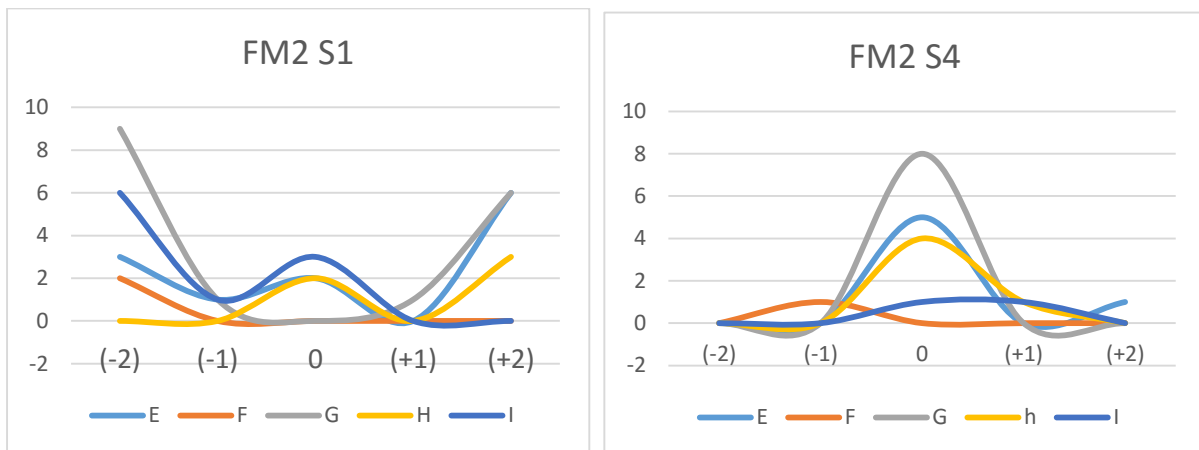
Finally, this research also raised an interesting question about the carer's capacity to understand and accept some of the child's behaviour as ways of coping, specifically at times when their own responses have become predominantly defensive. But again, pursuit of this question lay far beyond the constraints of the present research project.

Chapter 10: Conclusions and Some Recommendations

10.1   Reflections on methodology

10.2   Reflections on the findings and some recommendations

10.3   Concluding reflections on the unique role of the psychoanalytic child psychotherapist

Conclusions and Some Recommendations

Although this is a psychoanalytic research study, its conclusions and recommendations are mainly aimed at our social work colleagues working with looked-after children and their several families. These conclusions aim to highlight the contribution that psychoanalytic child psychotherapists can make in supporting foster carers, as well as the children in their care. Although this is a small-scale study, it was able to illuminate various ways in which some changes in policy might facilitate the process of recovery for these traumatized children, while improving the fostering experience of their carers.

10.1   Reflections on methodology

Although psychoanalytic clinicians, since the very beginnings of psychoanalytic practice by Breuer and Freud, are completely familiar with the case study method of research, the use of Grounded Theory was a novel journey for this researcher that required painstaking reading and re-reading of the voluminous data (almost 1,000 pages of session transcripts) and trust in the process. Yet, as it turned out, it was also highly reassuring to witness how the application of such a scrupulous methodology to the research data kept confirming that the theoretical concepts known and developed by psychoanalysts through the decades are so real and alive when applied to real people, carrying out the essential role of long-term carers, in highly stressful situations. Furthermore, although, at least at the beginning, the expectation (or at least the hope) undeniably was to discover new and ground-breaking knowledge, perhaps the main contribution of this study has been to find new ways of confirming and communicating insights that are probably reasonably familiar to psychoanalytically-trained clinicians. To this end, some of the main findings have been presented in the form of graphs. This is completely consonant with the ways in which most child psychotherapists actually work: as psychoanalytic child psychotherapists, in our day-to-day work we often find ourselves interpreting and trying to make sense of visual representations, in the shape of children's drawings. In a parallel way, this particular study has produced a series of visual expressions of psychoanalytic thinking, with the aim of furthering

communication about the nature of psychoanalytically-informed carer support, and hopefully offering new ways of illustrating, to the wider system, its beneficial outcomes.

10.2   Reflections on the findings and some recommendations

Winnicott once wisely wrote that one of the main aims of the analyst is to survive the patient:

> '*In doing psycho-analysis I aim at:*
>
> > *Keeping alive*
> >
> > *Keeping well*
> >
> > *Keeping awake. …*
>
> *Having begun an analysis I expect to continue with it, to survive it, and to end it.'* (Winnicott, 1962: 166)

Freud famously had earlier characterized psychoanalytic healing as one of the three '*impossible professions*' (the other two being education and government). (Freud, 1925: 273) It is not so different trying to be a 'good enough' long-term foster carer of a severely traumatized child: a well-nigh 'impossible profession' that most foster carers will do well to survive intact. When foster carers are faced with the almost impossible task of caring for a child who has suffered severe trauma in its early life, they often find themselves in the position where they have to go beyond the simple 'I know how you feel' sympathetic response. Much of the time, the child's communication of distress, hopelessness and despair can be so powerful that carers are in a position where their natural empathy towards the child (which usually brings them into the caring job in the first place) makes them feel their child's intense feelings, often without fully realizing that this is what is actually going on.

For some carers, these powerful emotional states evoked by the child in their care can feel completely alien and incomprehensible; while for other carers, they trigger memories of their own childhood, whether conscious or unconscious, which can be quite overwhelming for them. Surviving these very difficult emotional states then

becomes the carer's number one task. It is hardly surprising, then, that the child's communication of the experience of trauma (through the compulsion to repeat, in its various forms) is at times met with a self-protective defensive response on the part of the carer. Although the ways in which carers respond are very individual, depending on their own early life experiences, this study, applying Grounded Theory, suggests that these responses can be categorized as 'good enough' (receptive, empathic and non-defensive responses), 'identification and distancing' from the child, or/and 'identification and merging' with the child. However (and this is the most encouraging research outcome), it also becomes evident from this study that even short-term psychoanalytically-informed parent work considerably reduces the levels of the carers' defensive responses to the child's compulsion to repeat its trauma and increases the level of 'good enough' parenting responses to the child.

In thinking further about this range of carers' responses, this study also demonstrates that, when dealing with children who have suffered significant early trauma, it sometimes takes more than one person to help the child safely bridge the gap between their incoherent sense of their own narrative, a narrative that has been shaped by adaptation to their traumatic experiences (i.e., subject to the overriding imperative of psychological, and in some cases physical, survival), and a new narrative of self that is in the realm of 'good enough', in which some acknowledgement of the past can take place without feeling too threatened or overwhelmed in the process. To assist a traumatized child in this transition, and to survive the journey themselves, foster carers have to master a delicate balancing act between 'distance from' and 'closeness to' the intense emotional experiences presented by the child. For a lone carer (whether single or in a couple), this can be an extremely intense and demanding task: to attend to both the child's individual needs and the context of the wider world. A supportive and attentive third (a partner, a social worker or a therapist) can make this process of metabolizing the impact of the child's trauma, while keeping external reality in mind, much more manageable, by breaking it up into discrete episodes of closeness and distance, until a more coherent approach can be developed and managed by all. For example, there may be times when the foster mother will have to experience something similar to what Winnicott referred to as 'maternal preoccupation', or what Bion called maternal 'reverie', and she may need help from others to ensure that her

own needs (her emotional and other needs) are not being overlooked, because of her absorption in the child. However, it must always be kept in mind that, in the face of the reliving of a severe trauma, all of us can at times feel overwhelmed and come under intense pressure to respond accordingly.

In this particular study, all the participant families consisted of both foster mother and foster father, and the research data indicated clearly that the psychological resilience of a carer, who is constantly subject to the force of the child's compulsion to repeat, and the very viability of the placement overall, can be significantly strengthened by the involvement of both carers; and particularly when carers are supported to keep in mind each other as well as the foster child, as well as other family members. In other words, it is important to consider and engage all available caring resources.

It was evident from the nomination and selection of the participants in this study that the role of a father figure was generally underestimated, both in the foster family setting and in considering the child's early experiences. In most cases, the child's early experiences included males who tended to be violent, substance abusers, and/or were known sex offenders. This early, formative experience of men will almost certainly significantly colour the foster child's transference relationship to the foster father, yet this factor did not seem to figure much at all in the wider thinking about the placement. This highlights the importance of paying close attention to the child's relationship with (and emotional impact on) all the family members. Not only can proactively involving foster fathers in the various aspects of fostering strengthen the placement, but the specifically psychoanalytic insight into the typical transference relationships of traumatized children may also shed some helpful light on why some of the foster fathers report that they feel that the child might make accusations against them if they set boundaries for the child or show the child affection.

This study also suggests that there is a significant gulf between the emotional tasks required of short-term and long-term foster care. Although they might not be mutually exclusive, there are certain components that long-term fostering must include, such as giving thought to the child's future trajectory, developmental stages and longer-term care plan. Although at first glance these might seem obvious, in my experience the child's future options are not always sufficiently considered or planned for. For example, based on other experiences of working with looked-after children, it is often

the case with severely traumatized children that puberty uncovers special difficulties (over and above the normal developmental challenges) that may have lain dormant (or at best been less obvious) for several years, and the placement suddenly comes under intense pressure or even breaks down. These developments might be completely unexpected by the system if the enduring impact of early trauma is overlooked, or if the original trauma is thought of only as an event in the distant past, over and done with; but the psychoanalytic training of child psychotherapists allows them to foresee many of these difficulties in later childhood and adolescence. By providing targeted help to the carers and wrap-around services in the form of advanced planning of support and the prediction of what can be realistically expected from a particular child, or the recognition of hopeful signs in the child's development, considerable savings can be made in terms of the emotional and financial cost of a sudden placement breakdown. In some cases, the conclusion may well be that the current placement will not withstand the forthcoming changes and challenges, in which case a transition to an alternative placement can be properly planned rather than dealt with as an emergency. However, this particular topic must remain a subject for further research.

One of the interesting points coming out of the current research (and this was firmly grounded in the data) is that a carer may not want to 'rock the boat', as it were, with either the child or Social Services, if the placement is expected to last only a year or so. In this case, the role of psychological parenting may be seen as less important in comparison to the task focus of more concrete parenting in the here-and-now (e.g., hygiene, formal education, sports). However, carers are more likely to invest their energy and time, not to mention their emotional resources, in addressing the more chronic difficulties presented by a foster child if the carer expects the placement to last until the end of the child's teenage years. This likelihood is particularly relevant to the carers with a tendency to distance themselves from the child's compulsion to repeat early traumatizing experiences. Thus, once again the findings of this research (particularly regarding the individual carer's capacity to provide consistent psychologically-minded parenting) may be used in the consideration of whether a particular carer is better suited to providing short-term care or long-term care; and in helping to give more thought to whether the particular carer should be encouraged to continue to care for the child long term, or whether the priority should become the

planning of a good ending to the current short-term placement and transition to the next placement. This research has demonstrated the likely problems associated with what Jane Rowe et al. have characterized as '"drift" into unplanned, long-term placements'. (Rowe et al., 1984: 231)

These issues underline the importance of making a clear distinction in the relevant Regulations between short-term and long-term fostering placements; and recognizing the peculiar value of long-term fostering in maximizing the child's feeling of security rather than condemning the child to a state of permanent insecurity. Although, strictly speaking, a fostering arrangement can never be permanent, the importance to the child in care of what Rowe et al. have termed *'"permanent" fostering*' should not be underestimated: '*For those children for whom neither return to parents nor adoption proves possible or suitable, "permanent" fostering could provide a valuable service*.' (Rowe et al., 1984: 230)

In thinking further about the initial matching process and the length of the placement, this study provides strong evidence that carers respond to the child's distress on a very personal level, largely informed by their own experiences of being parented. The carers' own unresolved psychological issues are often triggered by the child in their care and then repeated in the carer's transference towards the child (and, of course, towards the social workers and the therapist). This emphasizes the important role the carer's childhood experiences play in their capacity to provide 'good enough' psychological parenting for a traumatized child; which in turn emphasizes once more that, irrespective of the daunting financial pressures and the overall scarcity of resources in the wider system, the carer's own childhood experience is a significant indicator of the level of post-trauma affect that can be successfully metabolized by that particular carer; and this must be taken into account in the process of matching carer (or carer couple) to child. While it is recognized that trained psychoanalytic psychotherapists are simply too thin on the ground to be involved in the matching process for all placements, their involvement could usefully take the shape, for example, of regular workshops or work-discussion groups for those closely involved in the assessment and matching of long-term foster carers, together with the preparation of appropriate manuals or handbooks.

The relevant selection criterion for this study was explicitly children in long-term placements, and a particular focus of the research was on the question of how psychoanalytically-informed parent work can support carers in responding receptively and non-defensively to the child's compulsion to repeat the earlier trauma and the feelings associated with it, attributing a particular role to the carer's capacity to remain psychologically-minded towards the child at times when the child is distressed and/or distressing. This study has demonstrated that even short-term psychoanalytically-informed parent support can significantly increase the level of 'good enough' responses to the child's distress by enabling foster carers more often to remain psychologically-minded towards the child in their care. This is a valuable service provided by the child psychotherapist. The data analysis demonstrated that this type of support is able to shift the carer's preoccupations from what the child does to why the child does it, thus helping the carer to view the child's 'compulsion to repeat' behaviour as communication and thus gain a better understanding of the links between the child's past experiences and the present actions, which in turn allows the carer to recognize the difficulties and challenges as re-enactments of early traumas, rather than the carer's failure to provide good enough care or the child's unwillingness to bond, thus reducing the strain on the placement.

According to the Barnardo's report, *Family Minded: Supporting Children in Families Affected by Mental Illness*, by Jane Evans and Rebecca Fowler (2008: 3), one in every six adults in the United Kingdom experiences some form of mental illness during their lifetime. Many of these are bound to be parents and some of them are likely to be foster carers. Ten per cent of all female psychiatric patients in the UK have a child under one year old, and a full quarter of women referred for mental health treatment have a child under five years old. (Royal College of Psychiatrists, 2002) Although Barnardo's in Northern Ireland collaborates with the local Department of Health & Social Services 'Families Matter' policy, whereby support is offered for more family-focused outcomes, more integration and multi-agency working (DHSSPSNI, 2007), significant deficiencies remain in the collaboration between child and adult mental health services, and between those services and Social Services.

In this particular research study, all the birth mothers suffered from either diagnosed (4) or undiagnosed (1) mental health difficulties: including psychotic states, substance abuse, overdoses, depression, PTSD, etc. Most of the children in the study stayed with their birth mother until school age or until they had an older sibling starting school. One could speculate that, although health visitors are important in spotting and beginning to assess these difficulties, the full impact of the birth mother's mental illness on the child became evident only when the children or their eldest siblings became known to the wider community, principally through beginning school. Only one out of the five children was receiving additional psychological support prior to or during this study. Post the study, four of the participant children were referred and three were offered further therapeutic input. One of the children continued with the on-going supports being provided prior to the beginning of this study.

In conclusion, the information gathered and analysed in this research further emphasizes the important role that psychoanalytic child psychotherapists trained in infant observation can play in providing training for health visitors and social workers in the field of infant mental health, and in fostering a deeper understanding of the impact that parental mental ill-health has on the wellbeing and future prospects of the child.

10.3   Concluding reflections on the unique role of the psychoanalytic child psychotherapist

As was noted above (p. 159), it is often the case that the attention of a supportive third person (be it a partner, a social worker or a psychotherapist) is necessary to make much more manageable for the principal carer the process of metabolizing the impact of the child's trauma, while keeping external reality in mind, by breaking this process up into discrete episodes of closeness and distance, until a more coherent narrative can be developed and managed by all parties. Because of their training, psychoanalytic child psychotherapists are best placed to carry out this crucial task.

The key role of the psychoanalytic child psychotherapist as a member of a multi-disciplinary team can be summarized as follows:

- The psychoanalytic training of child psychotherapists allows them to:
  - understand the impact of traumatic early experience on the child's current modes of relating
  - foresee the future trajectory of the child's development in his or her later childhood and adolescence
  - assist carers effectively in providing psychological parenting and foresee future strains on the placement
  - support a transition to an alternative placement or respite, where necessary, thus avoiding a sudden breakdown of the placement
  - support other professionals in assessing and supporting carers.

- Psychoanalytic child psychotherapists trained in infant observation can play a crucially important role in providing training for health visitors and social workers in the field of infant mental health, and in fostering a deeper understanding of the lasting impact of parental mental ill-health on the wellbeing and future prospects of the child.

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Chapter 12: Appendices

Appendix 1

11 Participant information sheet 1A (child 4-7 years old)

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13 Participant information sheet 1C (adult)

14 Participant consent form 1D (child)

15 Participant consent form 1E (adult)

16 Participant consent form 1F (LAC services)

17 Protocol of disclosure 1G

I want to help foster families like yours to look after children like you. I need your help to do this.

THE FAMILY TRAUMA CENTRE

HELLO!

We will meet three times. We will talk, play or draw.

WEEK 1

WEEK 2
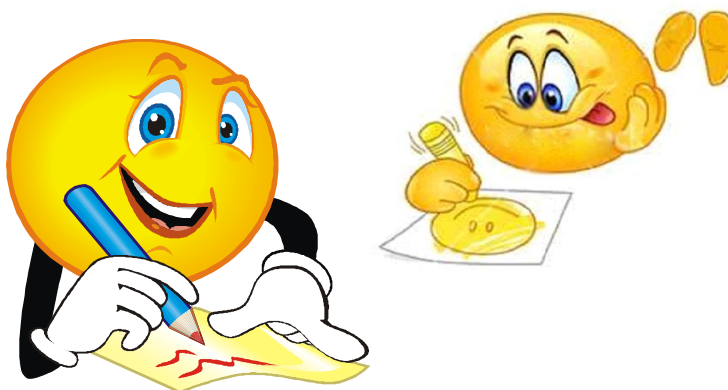
WEEK 3

Then we will say goodbye.

BYE!

After that, I will meet with your foster carer or carers. We will together think about you.
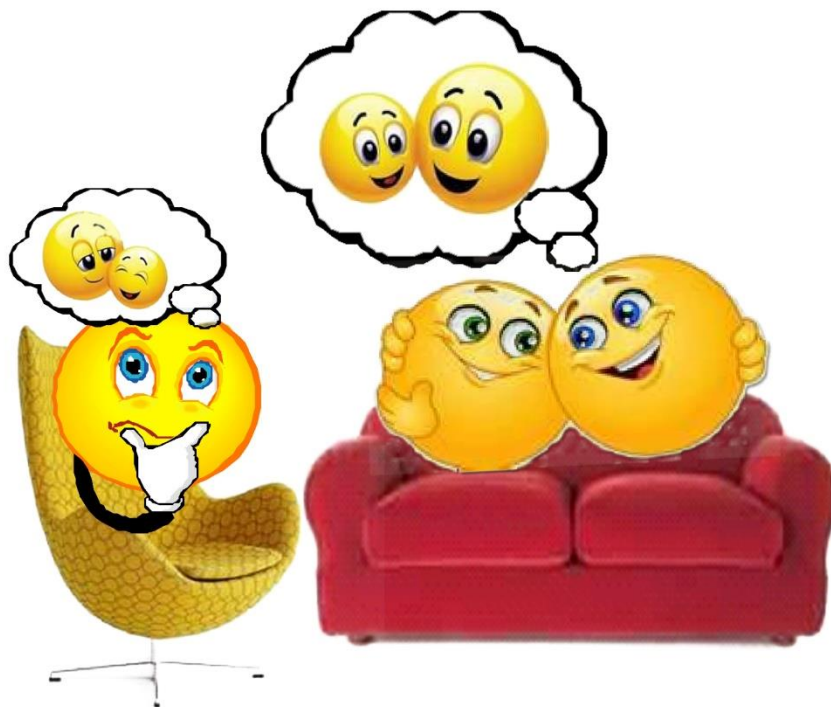
In the end I will write about all the families I meet. A pretend name will be used instead of your own.

Don't FORGET!

You can choose not to do this and that will be ok.

Challenges facing long-term foster carers: Exploration of the nature of psychoanalytic parent/carer support

Challenges facing long-term foster carers: Exploration of the nature of psychoanalytic parent/carer support

What is this about?

I want to find ways to help foster families like yours to look after children like you. I need your help to do this. This sheet tells you what is going to happen if you agree to take part.

What will happen?

To do this I will need to meet you first, and spend some time getting to know you. We will meet three times for just a little less than an hour. During this time you will be able to tell me a little bit about yourself. It will be up to you what you choose to talk about. Besides talking, we will have some toys and art materials that you can use.

What will be written down?

After each time we meet, I will write down some notes about our time together. After that, I will write a story about the things I have learned about you. In my story about you I will not be writing the things you tell me, only the things that helped me to understand you better. However, if I learn that for some reason you are not safe, I will have to talk to your social worker and your foster family.

What will happen after these meetings?

After meeting you, your foster carers and I will meet. We will be thinking about you together. I will meet them at least four times. When all the meetings with you and your foster family are finished, I will also meet with other families like yours. In the end I will write about all the families together. A pretend name will be used instead of your real name when I write my write-up – so no-one will know it's you I'm writing about.

What if I change my mind?

If you have any questions please ask me! You can decide not to do this at any time and that will be ok.

Kristine

APPENDIX 1B Version 3.4

28th March 2012

Participant Information Sheet
Research Title:
Challenges facing long-term foster carers: Exploration of the nature of psychoanalytic parent/carer support

You are being invited to take part in a research study. Before you decide whether or not to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please feel free to contact the research team if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish your family to take part. The things you share may contribute to how we help children and families in the future.

1. What is the purpose of the study?
The purpose of the study is to investigate the nature of short-term psychoanalytically-informed parent/carer work. The nature of the therapeutic intervention in this research will be the usual therapeutic support provided by child and adolescent psychoanalytic psychotherapists, using knowledge and skills developed in working with emotionally confused and confusing children. This research seeks to investigate the particular role of psychoanalytically-informed parent work with carers of Looked-After Children and the impact of psychoanalytic parent/carer support on the placement.

2. Why have I been invited?
You have been approached because you are an individual foster carer or foster carer couple currently parenting a looked-after child (aged 4-11) in a long-term placement. Other families have also been approached.

3. Does our family have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still

free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the service you receive now or at any point in the future from the Family Trauma Centre.

4. What happens if we agree to take part?

1) The lead researcher, Ms Kristine Tiltina, Trainee Child and Adolescent Psychotherapist, will set up an appointment with your family and the child's social worker to introduce you to the project.

2) Following this, separate appointments will be made for the child you are caring for and for you at the Family Trauma Centre.

- Three *State of mind assessment* sessions will be carried out with the child over three consecutive weeks. This is a specialist assessment that is normally used to provide understanding of the child's experience and understanding of relationships towards self and others. This assessment is based on observing and discussing deeper feelings and conflicts expressed by the child through words, play or drawings, in a 50-minute session dedicated entirely to the child. Written process notes will be completed after each session with the child.

- When you come for your appointment, you will meet with Kristine and you will be offered 4 psychoanalytically-informed parent support sessions on a weekly basis. Parent sessions will also last 50 minutes each and will be audio tape-recorded.

5. Will our details be kept confidential?

Should you agree to take part in this study, your personal details and interview tapes will be treated in the utmost confidence. The tapes will only be available to the researchers, Kristine Tiltina and Pauline Mahon. The tapes will be destroyed once they have been transcribed. The researchers will hold a copy of the data from the interviews, and no-one else will have access to it. The names of yourself, your family, your children or anyone else you mention in your

sessions will be kept strictly confidential. When the research is written up, false names will be used to protect your identity.

6. Are there any limits to confidentiality?

Yes, as with all research and other clinical interviews, should we be informed that you or your child or others are in danger; it is our responsibility as researchers to act accordingly, as per Healthcare Trust policy.

7. What will happen to the results of the research study?

The results will be written up in the form of an academic paper and submitted for publication within the next two years. Details of that publication will be provided to you on request. The results will also be written up as an academic requirement for the final Child Psychotherapy training programme of the lead researcher, Kristine Tiltina. You will not be identified in any such write-up. A summary of the results will also be sent to you should you wish.

8. Whom can I contact for further information?

Lead researcher:
Kristine Tiltina

Family Trauma Centre
1 Wellington Park
Belfast
BT9 6DJ

Phone: 028 9022 4700
kristine.tiltina@belfasttrust.hscni.net

Academic Supervisor:
Ms Biddy Youell

The Tavistock & Portman
Foundation Trust NHS
120 Belsize Lane
London
NW3 5BA

Researcher/Supervisor:
Pauline Mahon

Family Trauma Centre
1 Wellington Park
Belfast
BT9 6DJ

Phone: 028 9022 4700
pauline.mahon@belfasttrust.hscni.net

Academic Supervisor:
Mrs Margaret Rustin

The Tavistock & Portman
Foundation Trust NHS
120 Belsize Lane
London
NW3 5BA

Challenges facing long-term foster carers: Exploration of the nature of psychoanalytic parent/carer support

Name of child.. Age……………

Address: ....

....

....

Do you agree to take part?

Yes   **No**

Is it okay for me to write things down?

Yes   **No**

Can I choose not to do this and that will be ok?

Yes   **No**

NAME: ....   DATE: ....

Signed on behalf of researchers
Signed: .... Date: ………………………………
Print Name: ....

Research Code...

<u>*Participant Consent Form for carers*</u>
Research Title:
Challenges facing long-term foster carers: Exploration of the nature of psychoanalytic parent/carer support

Name of participant..............................
Address: ....
....

Please tick the box if you agree with the following statements:

1. I agree to participate in this research.   Yes   No

2. I have been given information and have had time to think and ask questions regarding this research.   Yes   No

3. I realize that I/we may withdraw from the study at any time   and this will not affect any treatment offered.   Yes   No

4. I have been given full information regarding the aims of the research and have been given the researchers' names and contact details if I require further information.   Yes   No

5. I agree that parent/ carer support sessions will be audio recorded and transcribed.   Yes   No

6. All personal information provided by me will remain confidential and no information that identifies me will be made publicly available.   Yes   No

Signed: .... Date: ....

Print name: ……………………………..

Signed on behalf of researchers

Signed: .... Date: ....

Print Name: ....
Research Code...................................

Participant Consent Form for Children for LAC team
representatives
Research Title:

Challenges facing long-term foster carers: Exploration of the nature of psychoanalytic parent/carer support

Name of child...
Child's date of birth …../…./….
Address: ....
....
....
Please tick the box if you agree with the following statements:

1. I agree to …………… …..participating in this research.

   Yes   No

2. I agree for three state of mind assessment sessions to be recorded in the form of written process notes.

   Yes   No

3. I have been given information and have had time to think about it and ask any questions I may have regarding this study.

   Yes   No

4. I realize that I/we may withdraw from the study at any time and this will not affect any treatment offered.

   Yes   No

5. I have been given full information regarding the aims of the research and have been given the researchers' names and contact details if I require further information.

   Yes   No

6. All personal information provided by my child will remain confidential and no information that identifies the child in my care or myself will be made publicly available.

Yes   No

Signed: .... Date: ....
(*by the Corporate parent*)
Print foster carer's name: ....
On behalf of …………………………………………. (Child's name)

Signed on behalf of researchers
Signed: .... Date: ....
Print Name: ....
Research Code...

Research Title:

Challenges facing long-term foster carers: Exploration of the nature of psychoanalytic parent/carer support
The protocol for disclosure

The Code of Practice on Protecting the Confidentiality of Service User Information (January 2009; p.26), chapter 5, point 5.7 states:

> *Information should be disclosed if it is necessary to protect the child or someone else from risk of death or serious harm. Such cases may arise, for example, if:*
> - *a child or young person is at risk of neglect or sexual, physical or emotional abuse;*
> - *the information would help in the prevention, detection or prosecution of serious crime, usually crime against the person;*
> - *a child or young person is involved in behaviour that might put them or others at risk of serious harm, such as serious addiction, self-harm or joy-riding.*
>
> *If disclosure is considered to be justified, disclose the information promptly to an appropriate person or authority and record your discussions and reasons. If disclosure is not justified, record your reasons for not disclosing.*

From the outset of this project the participant children, their foster carers and the social workers involved will be made aware that I have a responsibility to pass on any serious concerns should they arise during the process of undertaking this research. I will follow the duty to report guidelines:

- I will inform Ms Pauline Mahon, my supervisor at the Family Trauma Centre, if I have a concern about a child;

- I will inform the named social worker involved with the child;

- I will record all detailed and factual reports of any incidents that arouse concern, including completing UNOCINI (Understanding the Needs of Children in Northern Ireland) assessment where appropriate.

Signed: Date:

Appendix 2

- Sample coding of psychological-mindedness in one carer

- Psychological-mindedness (PM) & therapist's focus

- Levels of the carers' psychological-mindedness

TABLE 4 – Sample coding of psychological-mindedness in one carer

Mrs Morgan Session 1 (F1S1)

Par. No	2E	2F	2G	2H	2I		3E	3F	3G	3H	3I		CH	FC	
Total	-14	11	12	-9	-6	-6	0	0	0	0	0	0	-54	13	-41
1	-1		1			0						0			0
2						0						0	-1		-1
3	-1				1	0						0			0
4						0						0	-1		-1
5					1	1						0			0
6						0						0	-1		-1
7	-1	1				0						0			0
8						0						0	-1		-1
9			-1		-1	-2						0			0
10						0						0		1	1
11	1		1		-1	1						0			0
12						0						0		1	1
13			1			1						0			0
14						0						0	-1		-1
15						0						0			0
16						0						0	-		0
17	1		-1		1	1						0			0
18						0						0	-1	1	0
19	-1	1	-1			-1						0			0
20						0						0	-1		-1
21	-1		1		-1	-1						0			0
22						0						0	-1		-1
23						0						0			0
24						0						0	-1		-1
25						0						0			0
26						0						0	-1		-1
27						0						0			0
28						0						0	-1		-1
29						0						0			0

#															
30						0						0		1	1
31						0						0			0
32						0						0	-1		-1
33	-1			1		0						0			0
34						0						0	-1		-1
35	-1			-1		-2						0			0
36						0						0	-1		-1
37						0						0			0
38						0						0	-1		-1
39		1				1						0			0
40						0						0			0
41		1				1						0			0
42						0						0	-1		-1
43	-1			-1		-2						0			0
44						0						0			0
45	-1	-1		1		-1						0			0
46						0						0	-1		-1
47	-1	-1		-1		-3						0			0
48						0						0	-1		-1
49	-1			-1	-1	-3						0		-1	-1
50						0						0	-1		-1
51	-1					-1						0			0
52						0						0	-1		-1
53	-1		-1			-2						0			0
54						0						0	-1		-1
55	-1			-1		-2						0			0
56						0						0	-1		-1
57	-1			-1		-2						0			0
58						0						0	-1		-1
59						0						0			0
60						0						0	-1		-1
61				-1		-1						0			0
62						0						0		1	1
63	-1		-1	-1		-3						0			0
64						0						0			0

205

	G1	G2	G3	G4	G5	Sum	O1	O2	O3	O4	O5	Sum	B1	B2	Sum
65			1	-1		0						0			0
66						0						0		1	1
67	-1		1		-1	-1						0			0
68						0						0	-1		-1
69	-1			-1		-2						0			0
70						0						0			0
71						0						0			0
72						0						0			0
73						0						0			0
74						0						0			0
75					-1	-1						0			0
76						0						0		1	1
77						0						0			0
78				-1	-1	-2						0			0
79						0						0			0
80	1					1						0			0
81						0						0	-1		-1
82						0						0			0
83						0						0	-1		-1
84						0						0			0
85						0						0			0
86	-1					-1						0			0
87						0						0	-1		-1
88	-1					-1						0			0
89						0						0	-1		-1
90	-1			-1	-1	-3						0			0
91						0						0	-1		-1
92			-1		-1	-2						0			0
93						0						0			0
94	-1	1		-1	-1	-2						0			0
95						0						0	-1		-1
96	-1					-1						0			0
97						0						0			0
98	-1					-1						0			0
99						0						0			0

	G1	G2	G3	G4	G5	Σ	O1	O2	O3	O4	O5	Σ	B1	B2	Σ
100						0						0	-1		-1
101						0						0			0
102						0						0			0
103						0						0			0
104						0						0			0
105						0						0	-1		-1
106		1	1			2						0			0
107						0						0			0
108	-1		1			0						0			0
109						0						0			0
110			1			1						0			0
111						0						0	-1		-1
112						0						0			0
113			-1	-1	-1	-3						0			0
114						0						0	-1		-1
115	-1			-1	-1	-3						0			0
116						0						0	-1		-1
117	-1					-1						0			0
118						0						0			0
119						0						0			0
120						0						0			0
121						0						0			0
122						0						0			0
123						0						0			0
124						0						0			0
125	1		1		-1	1						0			0
126						0						0			0
127	1		1	1	1	4						0			0
128						0						0	-1		-1
129	1					1						0			0
130						0						0	-1		-1
131	1				1	2						0			0
132						0						0	-1		-1
133	1				1	2						0			0
134						0						0			0

207

#	G1	G2	G3	G4	G5	Sum	O1	O2	O3	O4	O5	Sum	B1	B2	Sum
135		1		1		2						0			0
136						0						0	-1		-1
137	-1			-1		-2						0			0
138						0						0		1	1
139	-1					-1						0			0
140						0						0		1	1
141						0						0			0
142						0						0			0
143	1		1	1	1	4						0			0
144						0						0	-1		-1
145						0						0			0
146						0						0			0
147						0						0			0
148						0						0			0
149			1			1						0			0
150						0						0			0
151	-1			-1		-2						0			0
152						0						0		1	1
153	-1					-1						0			0
154						0						0			0
155						0						0	-1		-1
156						0						0			0
157						0						0			0
158						0						0			0
159				-1		-1						0			0
160						0						0	-1		-1
161	1					1						0			0
162	1					1						0			0
163	1		1			2						0			0
164						0						0		1	1
165	1	1	1			3						0			0
166						0						0	-1		-1
167	1	1	1			3						0			0
168						0						0	-1		-1
169						0						0			0

170						0						0	-1		-1
171	1			1		2						0			0
172						0						0	-1		-1
173	1					1						0			0
174						0						0			0
175						0						0			0
176						0						0			0
177						0						0			0
178						0						0			0
179	-1			-1	-1	-3						0			0
180						0						0		1	1
181						0						0			0
182						0						0	-1		-1
183	1			1		2						0			0
184						0						0			0
185						0						0			0
186						0						0	-1		-1
187	-1					-1						0			0
188						0						0			0
189						0						0			0
190	1		1	1	1	4						0			0
191						0						0			0
192		1	1			2						0			0
193						0						0		1	1
194		1				1						0			0
195						0						0	-1		-1
196	1			1		2						0			0
197						0						0	-1		-1
198		1		1		2						0			0
199						0						0	-1		-1
200						0						0			0
201						0						0			0
202						0						0	-1		-1
203	1					1						0			0
204						0						0			0

209

205	-1					-1						0			0
206						0						0	1		1
207		1		-1		0						0			0
208						0						0	-1		-1
209						0						0			0
210						0						0			0
211						0						0		1	1
212						0						0			0
213						0						0			0
214						0						0			0
215			1	1		2						0			0
216						0						0	-1		-1
217						0						0			0
218						0						0			0
219						0						0			0

Psychological-mindedness & therapist's focus in Session 1

For FM1 S1 & T- FM1S1 – see main text

FM2S1

F3S1

FM3S1

FF3S1

T-F3S1

F4S1

FM4S1

FF4S1

T-F4S1

F5S1

FM1S5
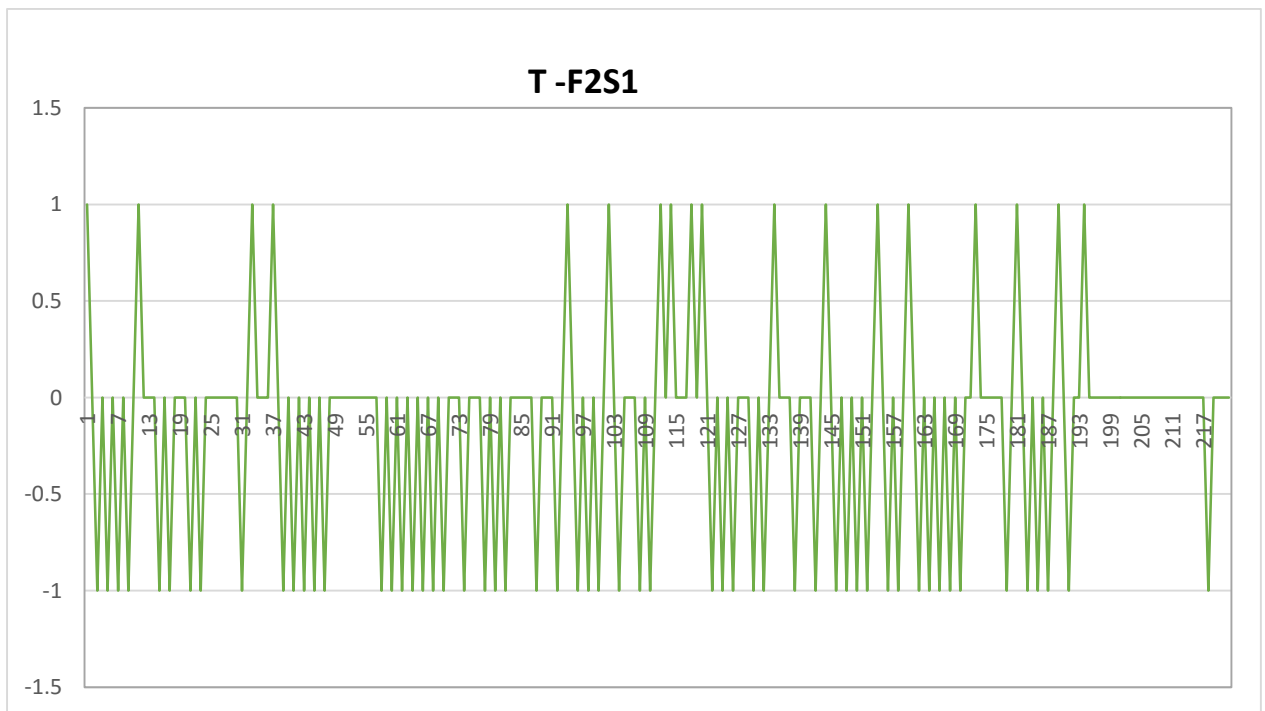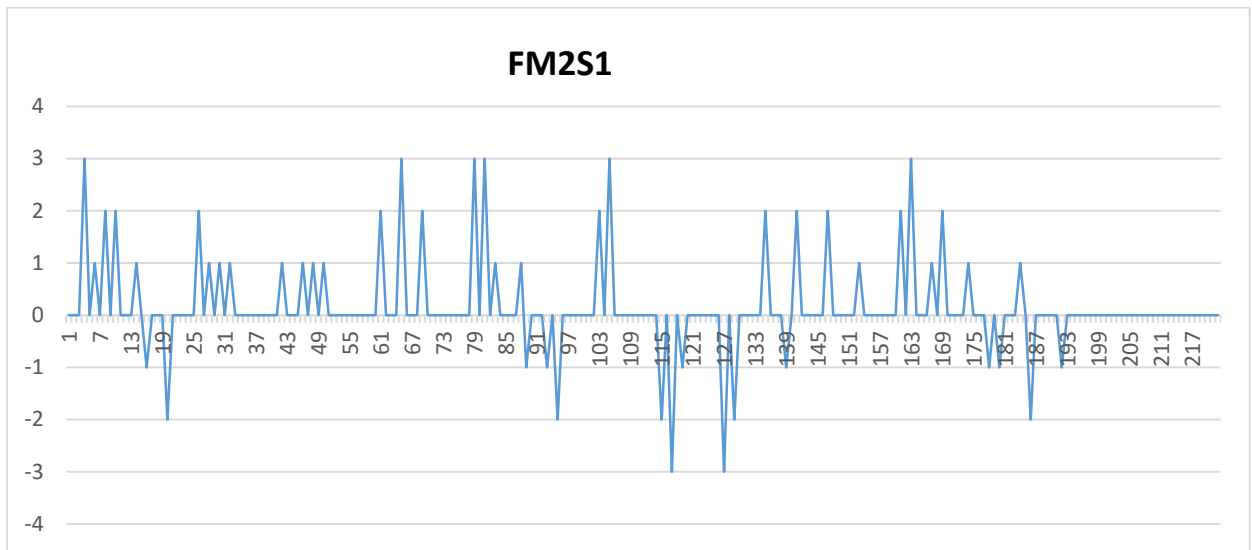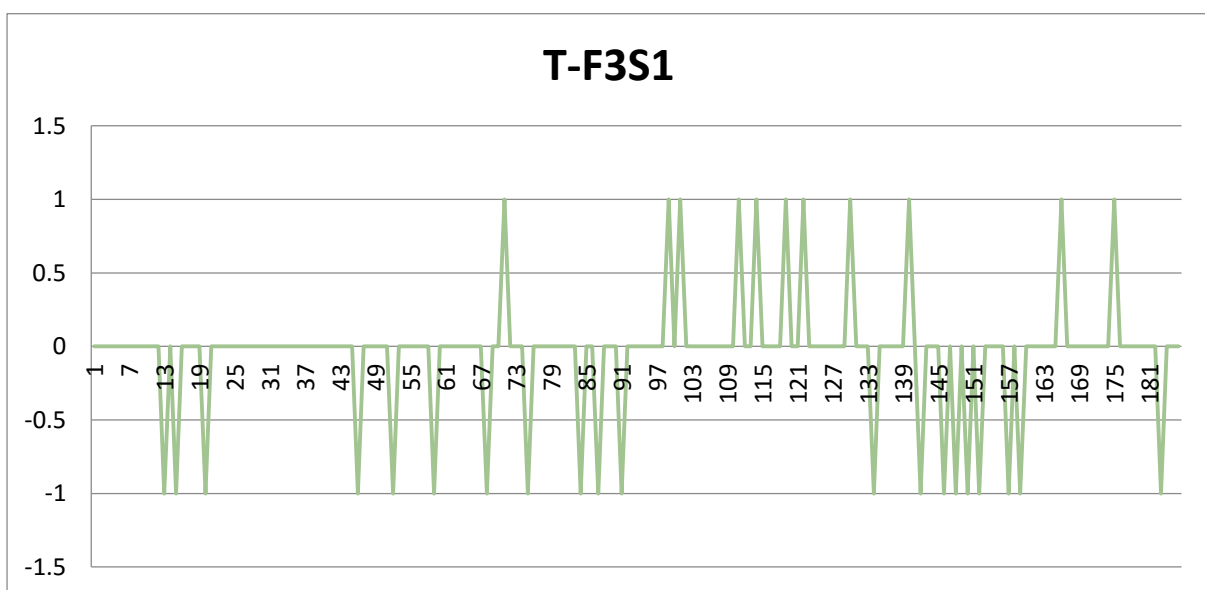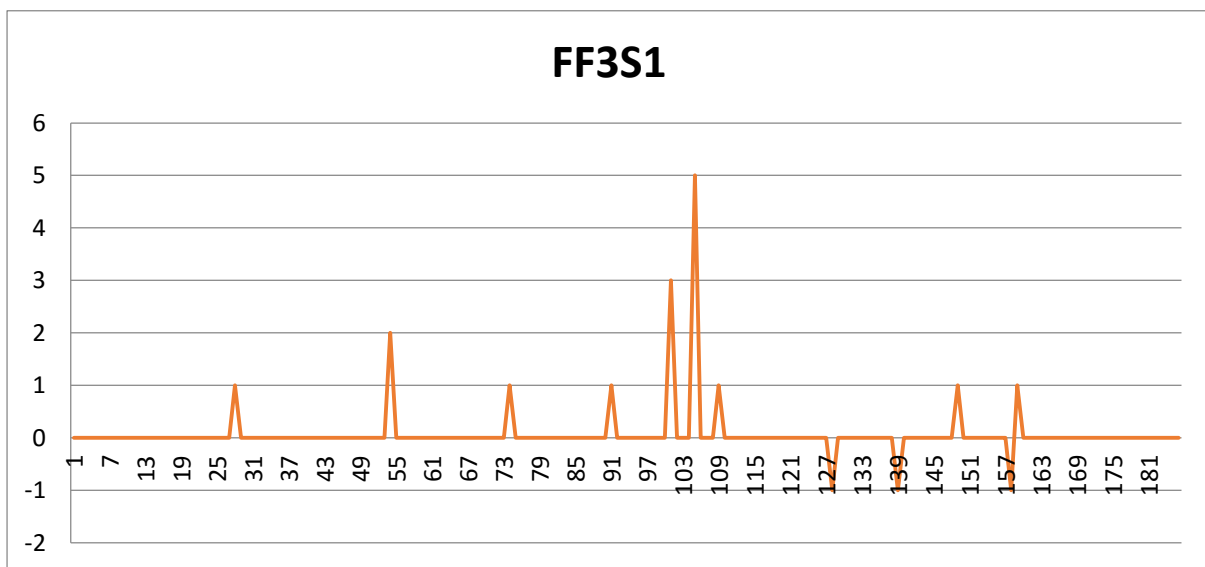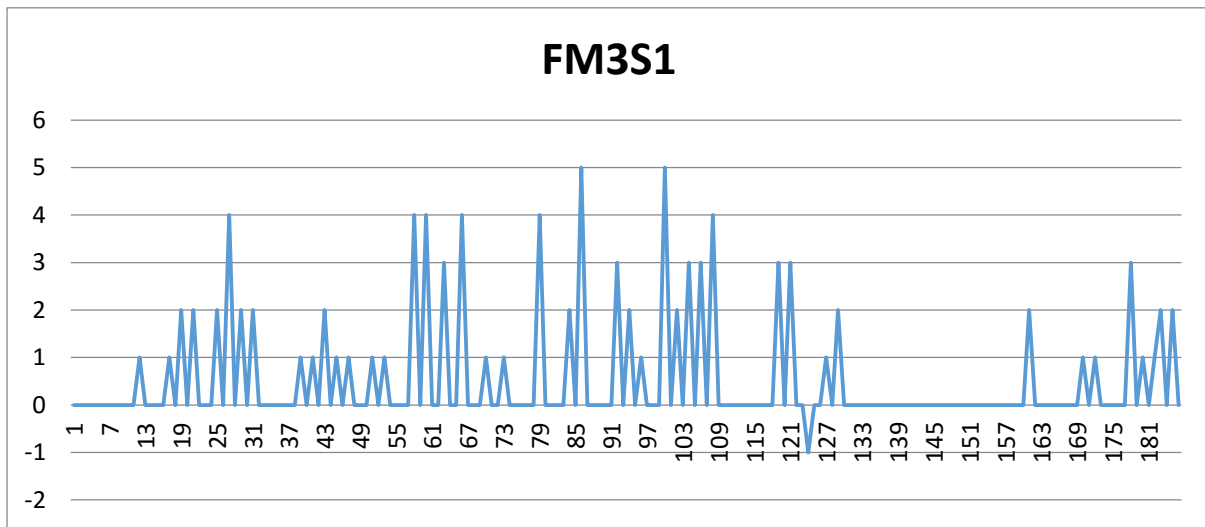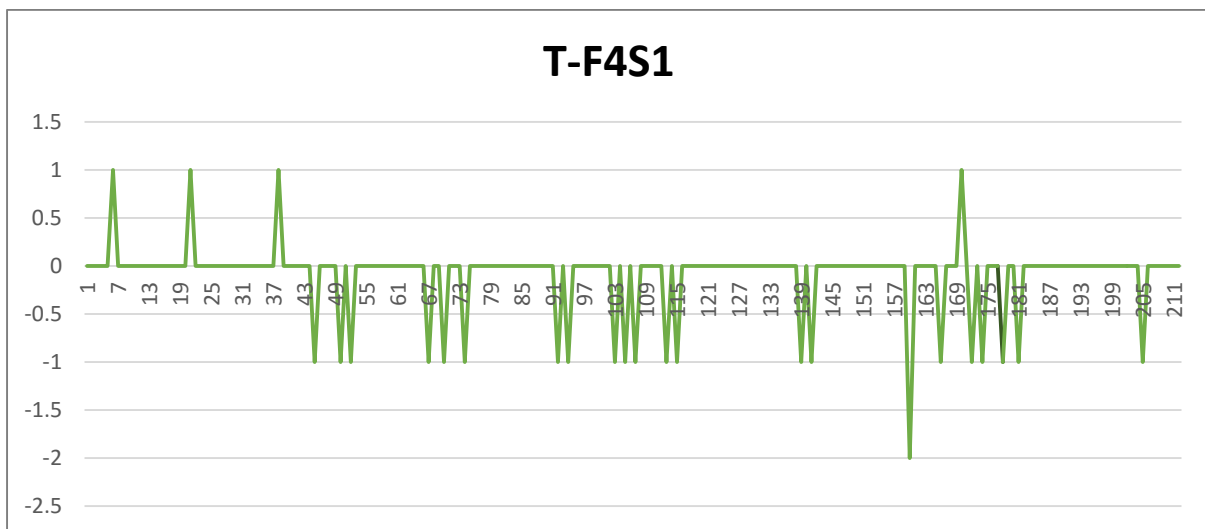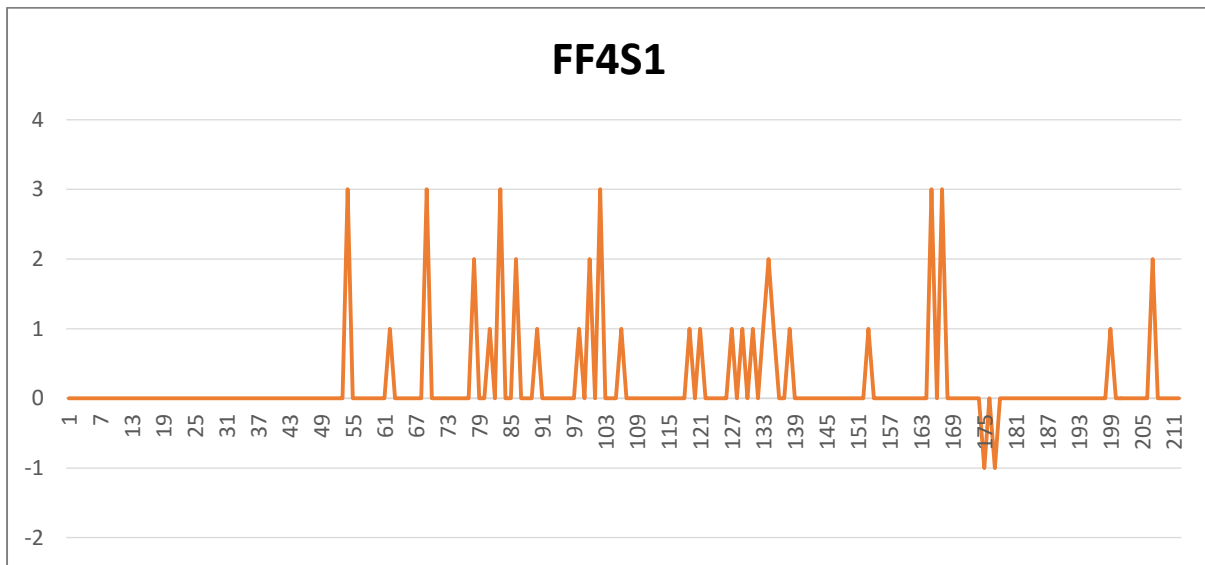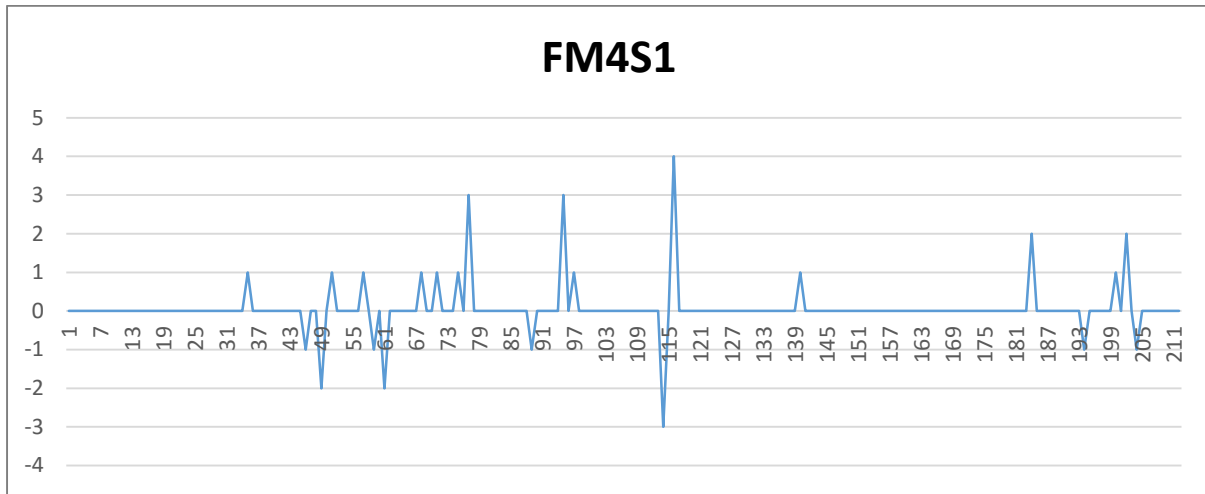
T-F5S1
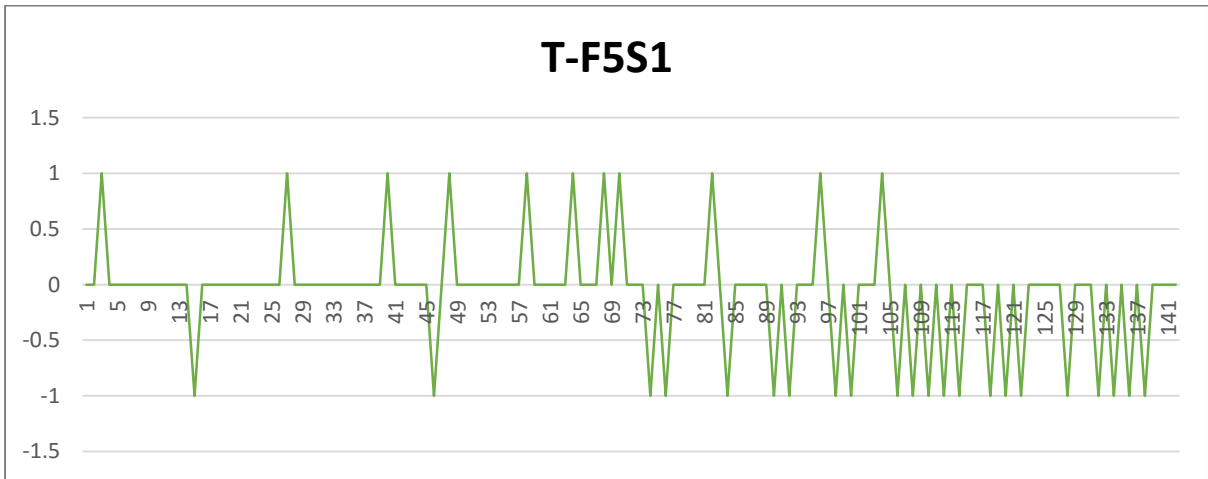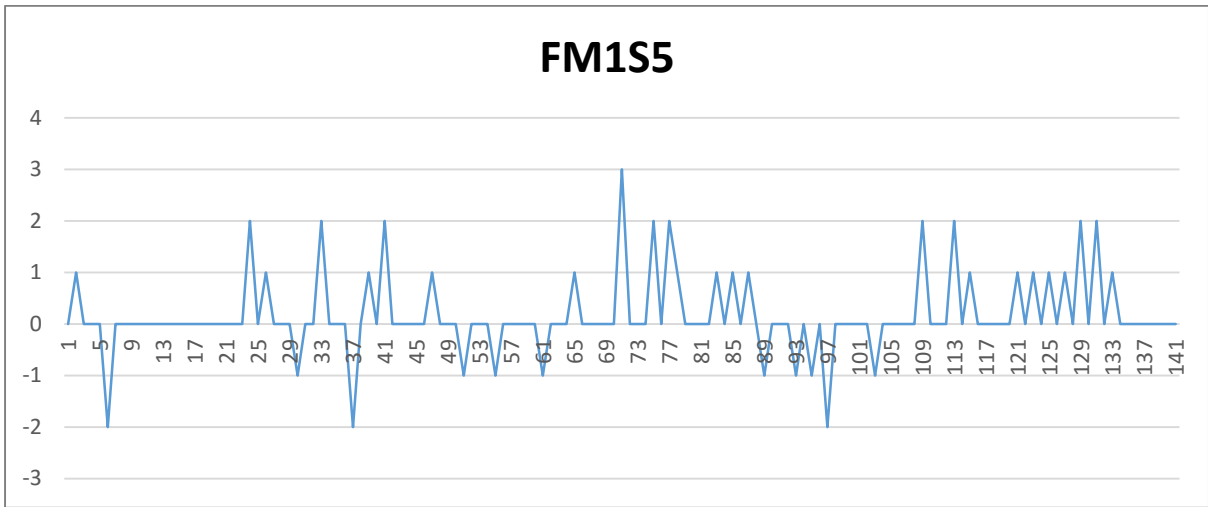
Changes in carers' levels of psychological-mindedness over four sessions

FM1 – see the main text

FM2
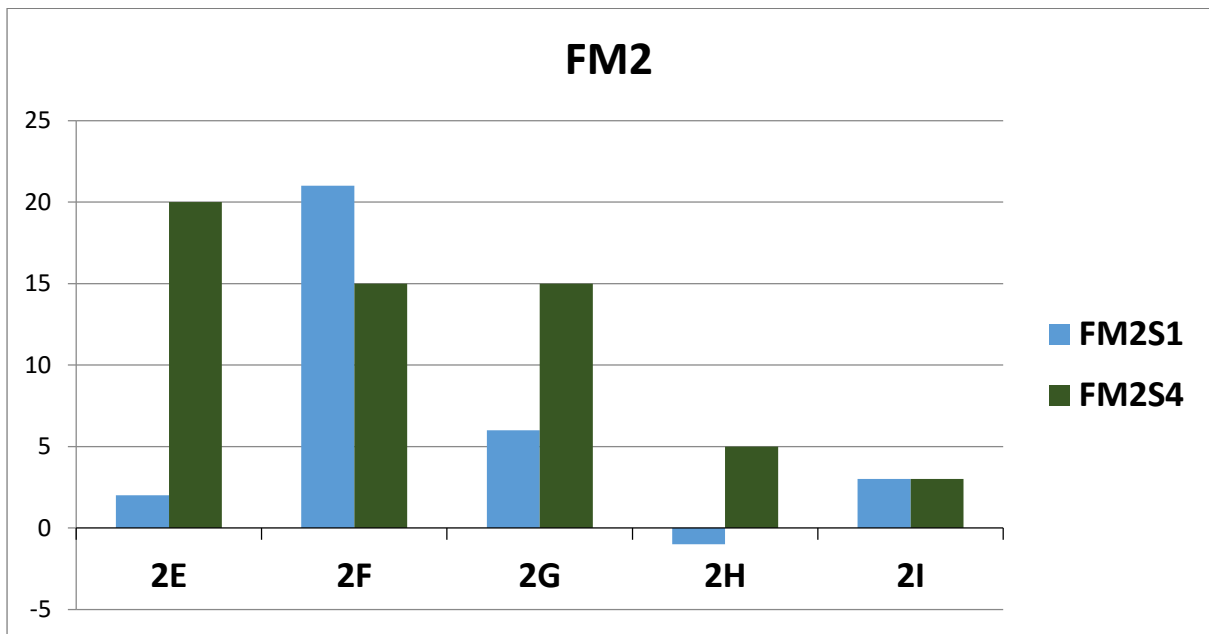
FM3 – see the main text above

FF3

FM4
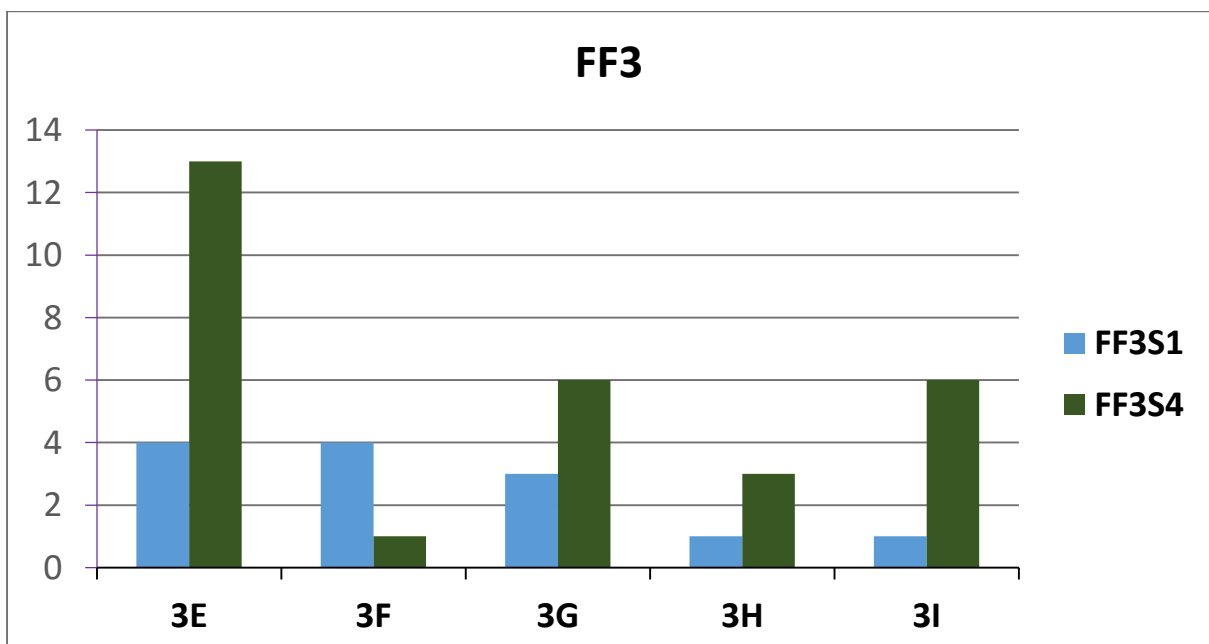
FM4
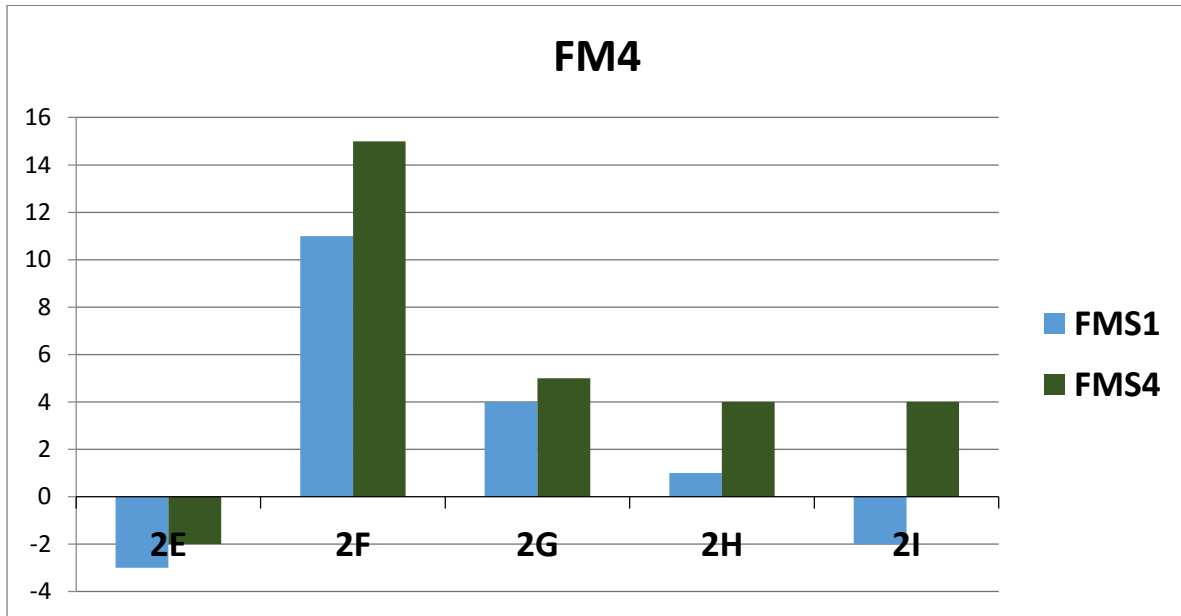
FF4 – the 4th session was not attended

FF4
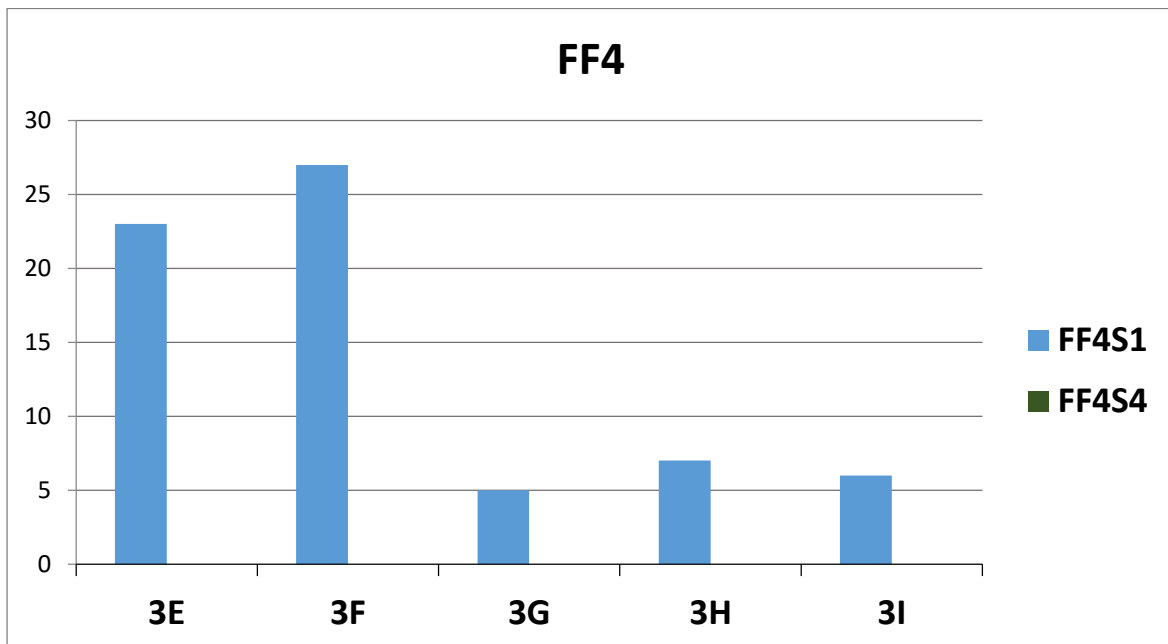
FM5
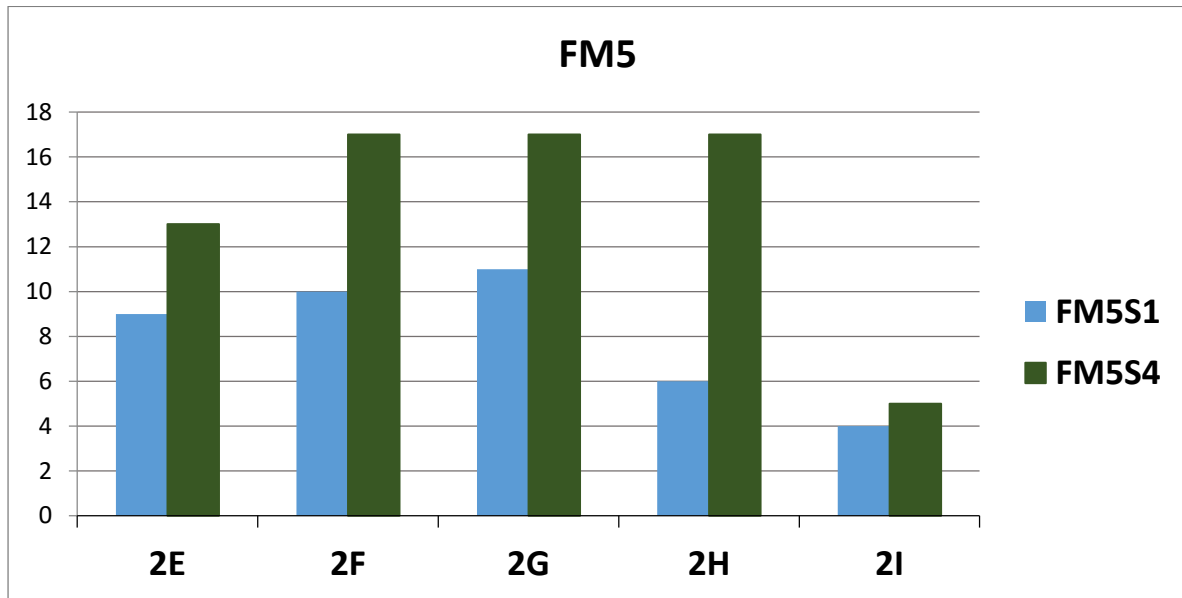
Appendix 3

18 Foster carers' individual responses to the child's compulsion to repeat distress or trauma

Foster carers' individual responses to the child's compulsion to repeat distress or trauma in the 1st and 4th sessions
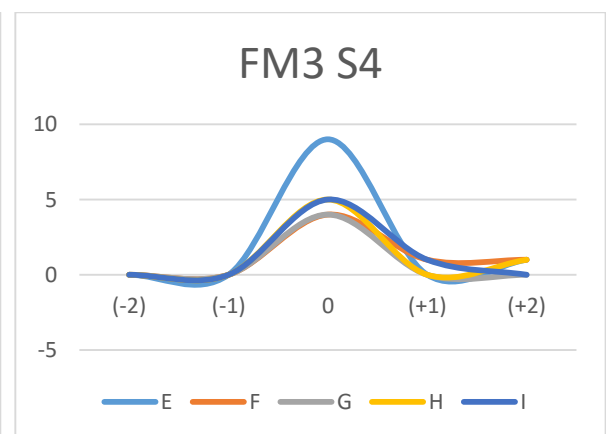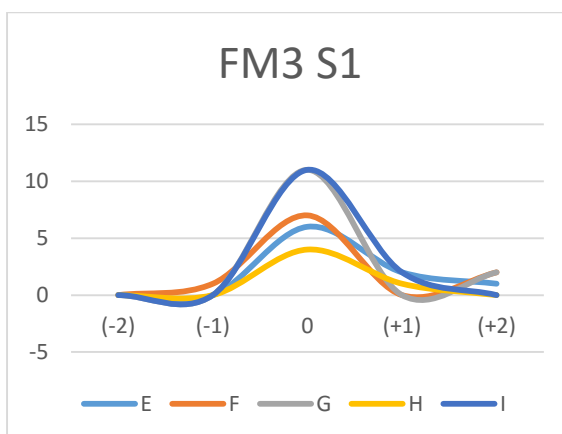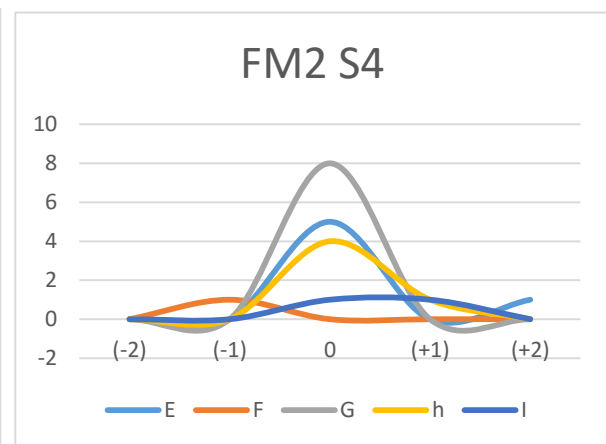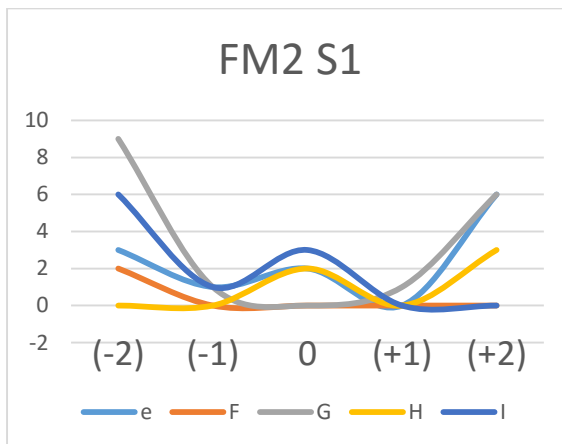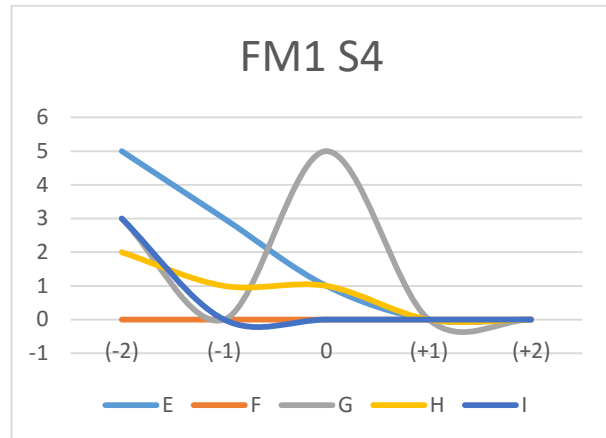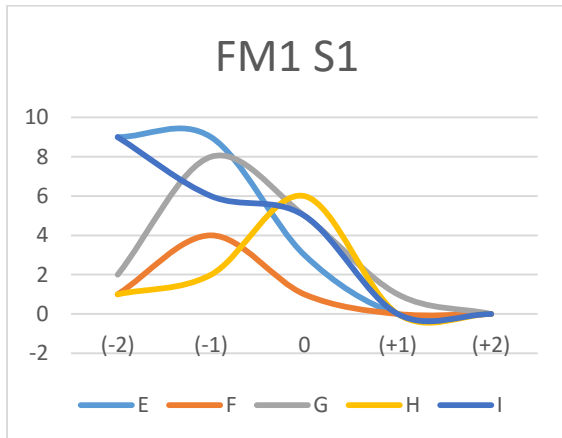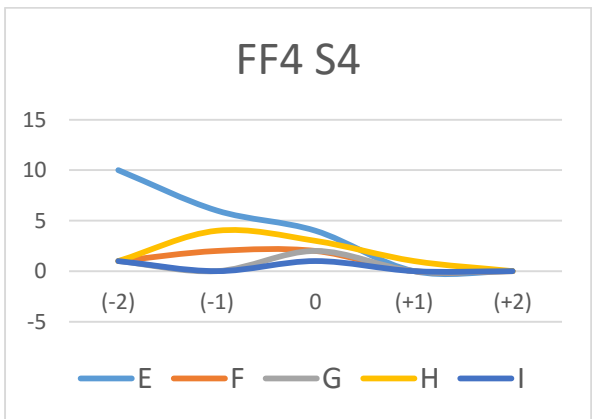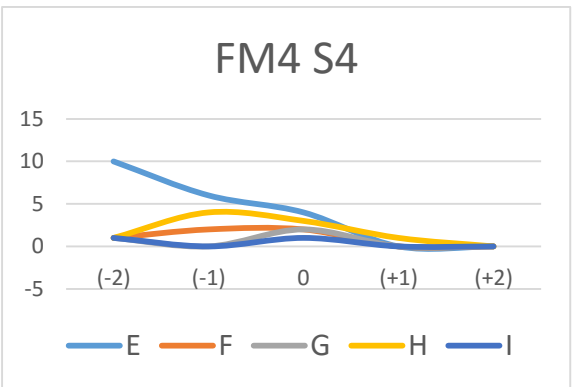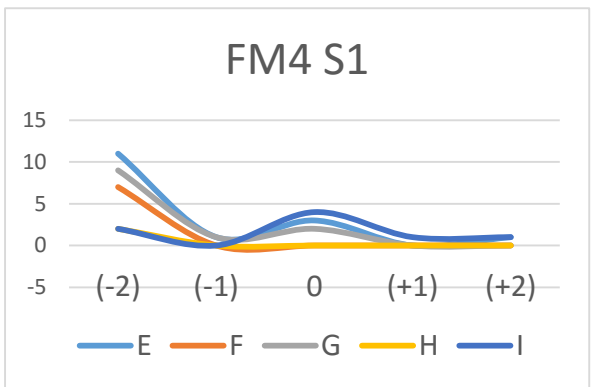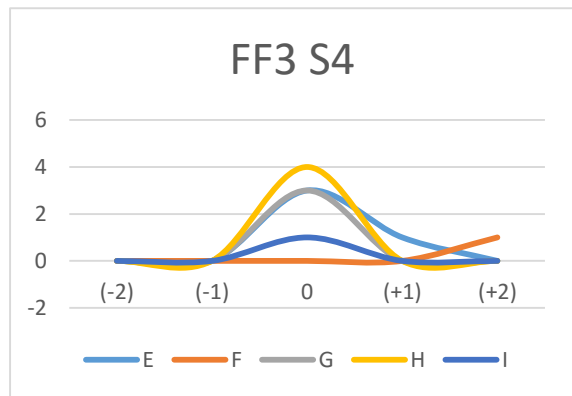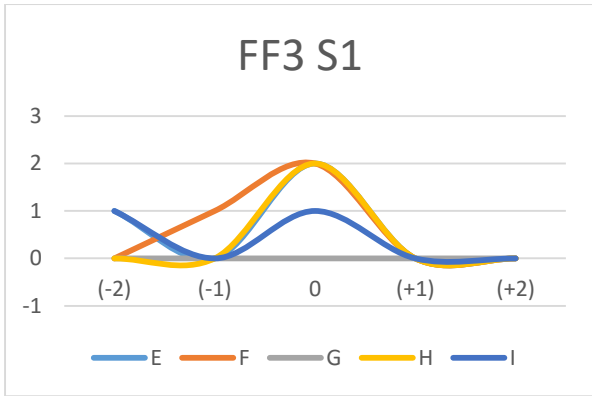
FF4 did not attend session 4
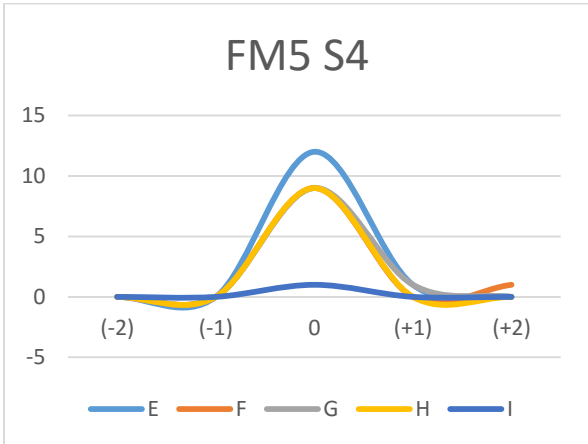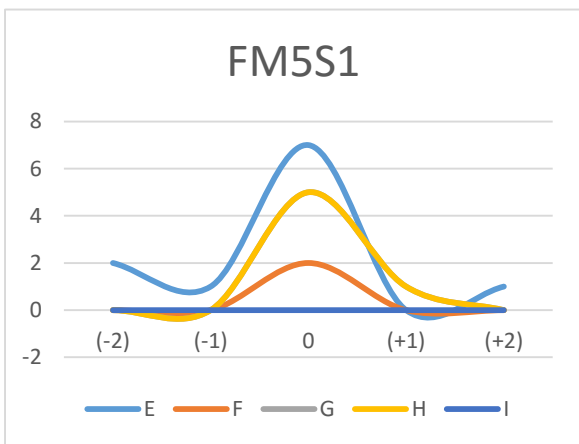
Appendix 4

19 The overall changes over four sessions in the carers' responses to the child's compulsion to repeat in the categories of E, F, G, H & I

The overall changes over four sessions in the carers' responses to the child's compulsion to repeat in the categories of E, F, G, H & I
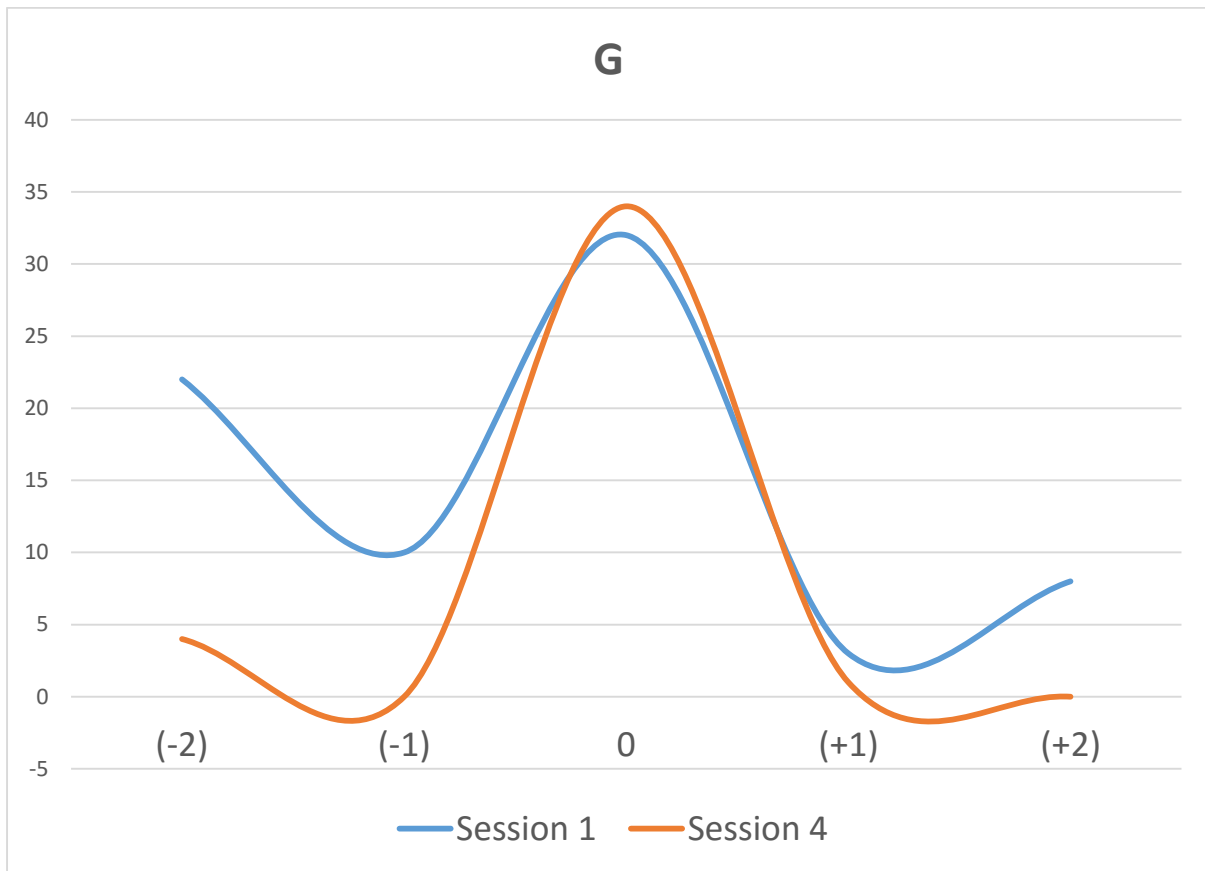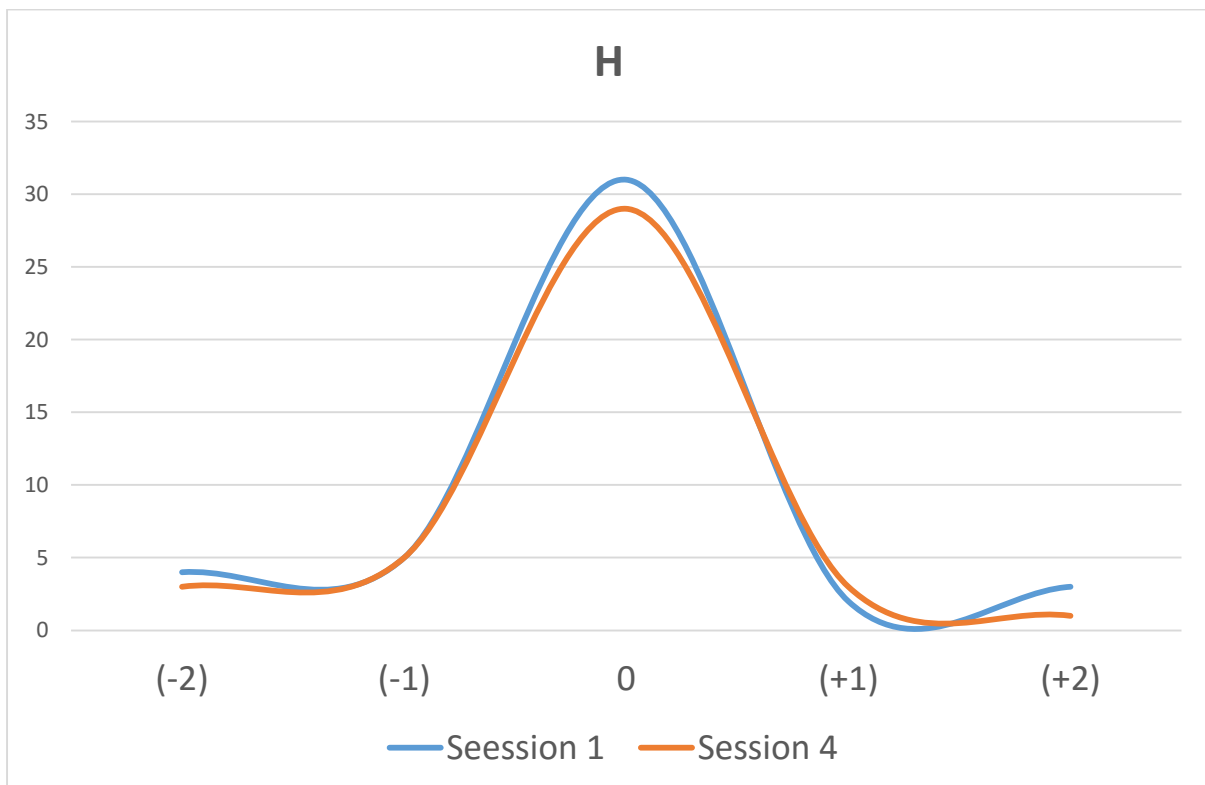
Insightful comments
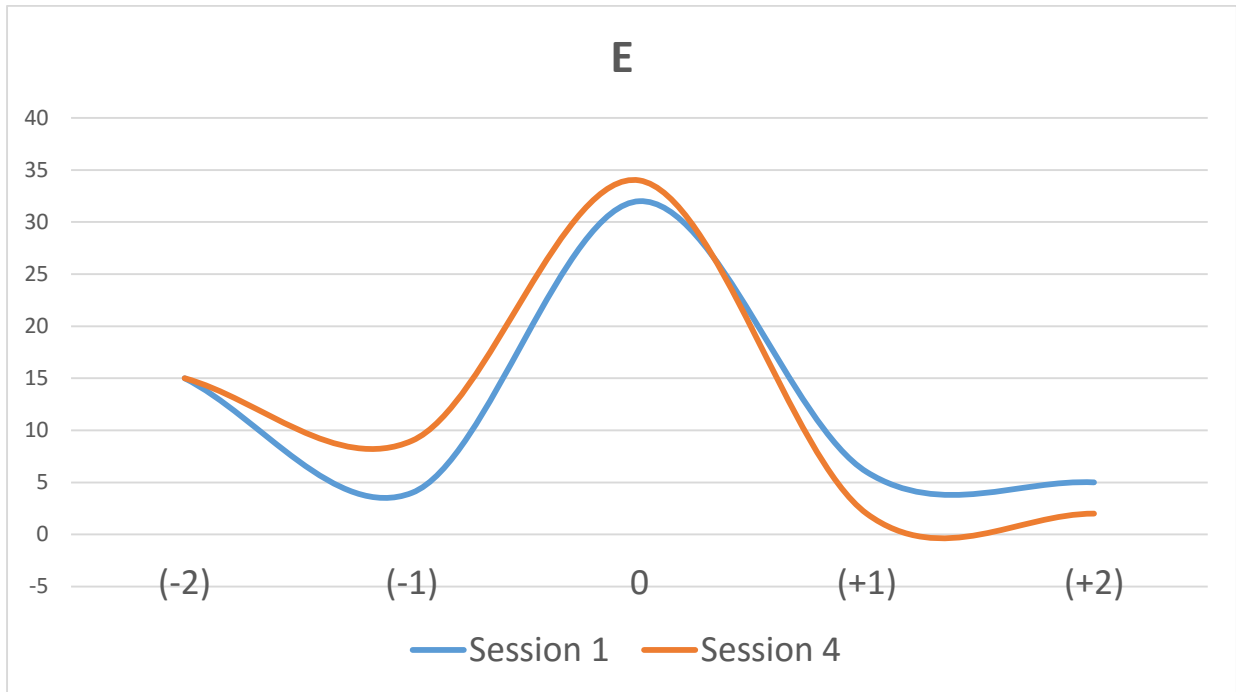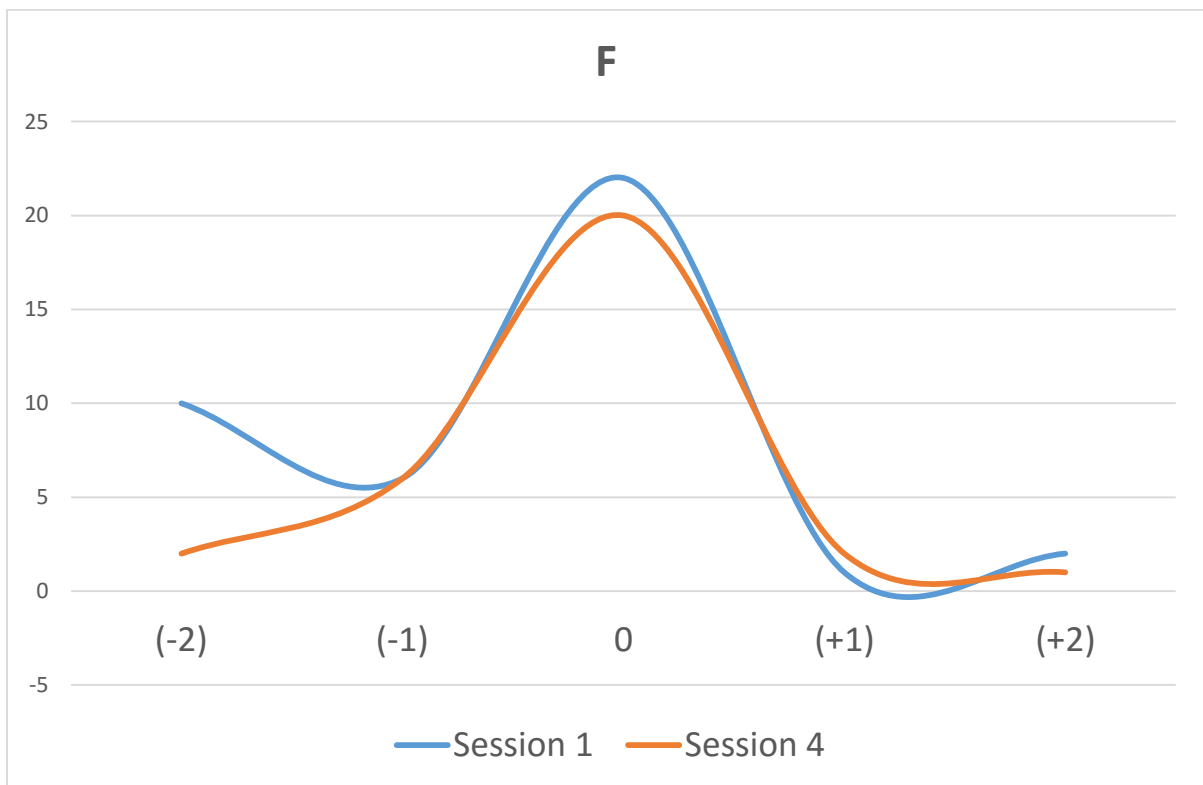
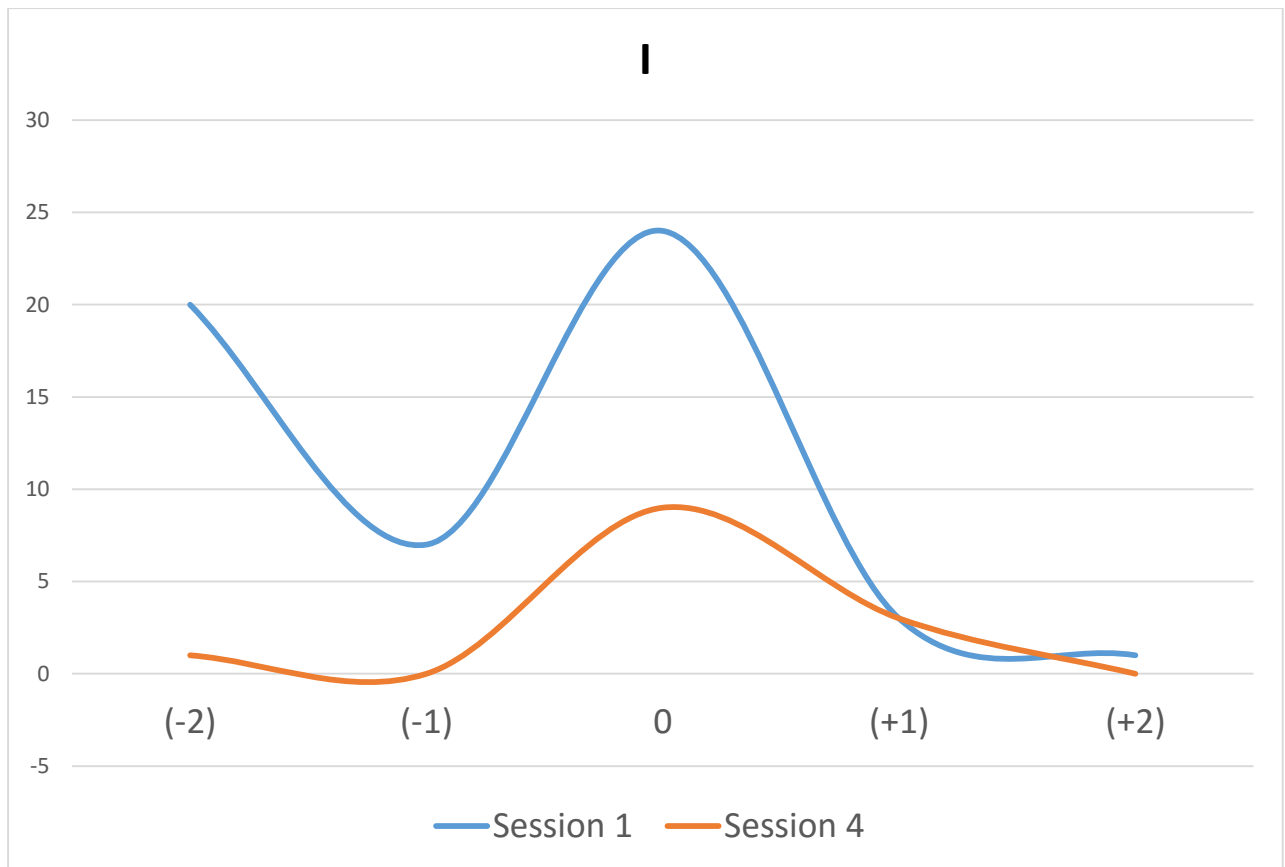**Awareness of the child's bodily states**

Awareness of the child's affect

G

Session 1 — Session 4

The carer's ability to recognize the child's defences

H

Seession 1 — Session 4

The carer's ability to make links between the children's presenting difficulties and the child's past experiences

THE END

UEL
University of
East London

Ms Kristine Tiltina

234 Ravenhill Avenue
Belfast
Northern Ireland
BT6 8LL

03 December 2014

Dear Ms Tiltina

**University of East London/The Tavistock and Portman NHS Foundation Trust:
research ethics**

**Study Title: *Challenges facing long term foster carers: Exploration of the
nature of Psychoanalytic parent/carer support***

I am writing to inform you that the University Research Ethics Committee (UREC)
has received your NHS approval letter, which you submitted to the Chair of UREC,
Professor Neville Punchard. Please take this letter as written confirmation that had
you applied for ethical clearance from our UREC at the appropriate time; it is likely it
would have been granted. However, this does not place you in exactly the same
position you would have been in had clearance been obtained in advance.
Therefore, when responding to any questioning regarding the ethical aspects of your
research, you must of course make reference to and explain these developments in
an open and transparent way.

For the avoidance of any doubt, or misunderstanding, please note that the content of
this letter extends only to those matters relating to the granting of ethical clearance.
If there are any other outstanding procedural matters, which need to be attended to,
they will be dealt with entirely separately as they fall entirely outside the remit of our
University Research Ethics Committee.

If you are in any doubt about whether, or not, there are any other outstanding matters you should contact Mr William Bannister at the Tavistock and Portman NHS Foundation Trust (e-mail WBannister@tavi-port.nhs.uk).

Yours sincerely

For and on behalf of
Professor Neville Punchard

c.c.   Mr Malcolm Allen, Dean of Postgraduate Studies, Tavistock and Portman NHS Foundation Trust
Mr Will Bannister, Associate Director, Education and Training, Tavistock and Portman NHS Foundation Trust
Professor John J Joughin, Vice-Chancellor, University of East London
Mr David G Woodhouse, Associate Head of Governance and Legal Services