# Exploring the challenges for the care network of providing therapeutic support for Unaccompanied Asylum-Seeking Minors

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## Abstract

Complexities limiting therapeutic engagement with unaccompanied minors observed in one CAMHS team, prompted a qualitative and explorative study into how these young people's needs were attended to by their care networks. An overarching Psychoanalytic framework and the use of Thematic Analysis was applied to data collected from audio recorded group discussions held over six weeks with foster carers, and from semi-structed interviews with a variety of professionals who have had experience of working with unaccompanied minors. The research question was to look at what the challenges were for these two groups in the care network with the aim to highlight the complexities and difficulties within these relationships, whilst at the same time enhancing understanding of the intricacies of their interactions, including positive experiences.

Findings from the foster carer group suggested they often took a *"Detective Mother"* stance, attempting to understand and make connections when faced with multiple uncertainties and unknowns. However, this instigated fear, mistrust, and caution of what might be internalised or enlivened within relationships resulting in the need for distance. Professionals emphasised their struggles with time pressures and the feeling of 'trying to get it right' in terms of provision offered and their communication, which ultimately ignited feelings of guilt and shame. The flight to normalise behaviours and position themselves in the shoes of the 'other' dulled down the ambiguity and trauma they often faced.

Overall, these findings highlighted that one of the greatest challenges was identifying and remaining in touch with a young person's needs when there were significant traumas and multiple layers of deprivation to contend with. In addition, difference and diversity had an impact upon the ability and availability to offer care which it is argued became laced with unconscious animosity and institutional racism which was perpetuated within the system. It concludes care networks would benefit from detailed and specific training, as well as safe, non-judgemental spaces to engage in conversations about the challenges and successes of supporting unaccompanied minors. The study also suggests that a consideration of unconscious biases and racism, including those at a societal and political level as well as how trauma becomes enlivened within relationships can be advantageous in understanding how therapeutic engagement can be obstructed and obfuscated.

**Key Words:** *unaccompanied asylum-seeking minors, care network, trauma, counter transference, deprivation, institutional racism.*

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## Acknowledgements

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## Introduction

I feel it is helpful to begin by offering a brief description and overview of what is meant in this research study when an individual is referred to as an Unaccompanied Asylum Seeking Minor/Child (UAM/UASC),

> *An unaccompanied asylum-seeking child is a person under 18, or who, in the absence of documentary evidence establishing age, appears to be under that age, is applying for asylum in his or her own right and has no relative or guardian in the UK* (gov.uk, 2017).

These young people have often been separated from their families and arrive in the UK alone, confused, and startled. Separated children are often at real risk from suffering poor mental health and post-traumatic stress due both to their experiences in their home countries and the gruelling and dangerous journey they are forced to take to reach safety. Many of these young people may have also witnessed the death of family members or been abused themselves prior to leaving home or on their journeys.

It is also effective to provide clarity to two terms that will be used throughout this paper and refine the meaning I have attributed to them. The term 'Care Network' refers to those closest to the young person when residing in the UK. This might be their foster carer, social worker, or therapist, for example. It includes those with 'loco parentis' (parental responsibility) who communicate and share information between themselves to support a young person. Thus, assisting and promoting integration, health, and wellbeing, with the individual's needs at the centre of their thinking. It also acknowledges that there are other key workers who support an unaccompanied minor, such as paediatricians and teachers for example, who might also take on this 'parental role' for a young person.

'Theraputic Support' incorporates different layers of professionalism, including individuals who offer time and space to support and encourage emotional engagement, at the right time to an individual and their presenting needs. This might be via 1:1 sessions or conversations and group work for example, and include verbal and non-verbal methods. These spaces are often offered by individuals such as CAMHS professionals, foster carers, or social care staff. They are healing in nature and aspire to cultivate positive outcomes physiologically and psychologically.

## Background and Interests

At the time this study was conducted I was a trainee Child and Adolescent Psychotherapist in doctoral training with the Tavistock and Portman NHS Foundation Trust, linked to the University of East London. My training placement was within a generic CAMHS in the South West region and as part of my role I was linked to the Looked After Children's (LAC) Team. I noticed over a couple of years of working within this team, referrals regarding the mental health concerns of unaccompanied asylum-seeking minors were steadily increasing. These often consisted of multilayered and co-morbid presentations of various needs and levels of trauma and emotional turmoil. Although there was this rise in referrals, little direct work was offered to these individuals who were instead treated with medication or offered infrequent medical reviews to explore this option over time. It had also been noted by the team that during this same period no referrals were made regarding the risk of placement breakdowns where unaccompanied minors were placed. This was startingly different to the referrals received regarding indigenous young people, which was usually one of the highest risks mentioned within referrals.

There are several examples across the UK where direct work is successful in treating several mental health complaints with this group of individuals and their support networks too. So, I was curious about how and why this differed in my service. I wanted to find out more about the experiences of working and living with these young people who had suffered high levels of trauma and if this subsequently had an impact and influence upon the therapeutic work that was or was not being offered. Rather than working directly with young people I wanted to understand the potential limitations and reluctances that were perhaps making such contact with them particularly challenging, understanding it from the perspectives of the professional network around them. I also wanted to explore the placement contrasts in foster care with indigenous young people from the network's perspective. To date, both areas seem to have little focus and attention within the immediate services, and more widely regarding historic research.

A meeting in February 2017 with the Head of service for Looked after Children in the locality and two lead professionals from the Fostering Team and Unaccompanied Asylum-Seeking Children's Team highlighted an interest in this area of study. There was a hope that the research findings could increase the understanding of working and living with unaccompanied minors

from the perspectives of those in the network around them, thus contributing towards enhancing the quality of service provided to them. Therefore, it was deemed that this would be achievable and a useful piece of research.

I was hopeful that my training as a Child and Adolescent Psychotherapist would bring a unique set of skills to the researcher perspective, and although I was not intending to work with these young people directly, I hoped that I would be able to gather a wealth of data from not only the raw data, but the feelings stirred, and emotions evoked from the participants and within myself.

> *A fundamental part of the training of psychoanalytic psychotherapists is to learn to attend to the material that patients bring on a number of different levels, including attending to the feelings it evokes in themselves. This is just as important in working with groups and institutions. We can 'hear' and learn a great deal if we are able to attend to atmosphere and to our own feelings, and not just to what is actually being said* (Moylan, 2019, p.21).

I was curious from my experience of meeting with, assessing and providing brief work with these young people and their networks, about the powerful undigested pain that was perhaps acted out unconsciously within their relationships and interactions with those working closely with them which could be immobilizing and restricting of growth and connectivity. Considering my training and experience, using a Psychoanalytic framework and understanding felt the most appropriate lens through which to approach data collection, literature evaluation and subsequent data analysis and findings.

**Study Aims**

The main aim was to explore the challenges of the care network of providing therapeutic support to unaccompanied minors and I wanted to do so via interviews and support groups with professionals and foster carers who worked with these individuals and formed their networks. I hoped to elicit some thinking about the impact of living, working, and connecting with these young people. I was interested in exploring the foster carers' perspectives, as well as professionals, so my aim was to provide a small and safe group setting where foster carers could explore key themes they were contending with on a frequent basis when living with unaccompanied minors. Although relevant themes were noted and joined together each time they met, the conversations were free-associative which enabled the participants to venture into topics as and when they pleased. The hope was that through honest discussion and careful

contemplation, behaviours, attitudes and emotional responses could be better understood, thus having a beneficial and in-direct therapeutic impact within a placement. For professionals, I wanted to be as flexible as possible to offer a familiar, non-threatening space to ask questions about their professional experiences when working with and supporting unaccompanied minors, as well as attempting to encourage the exploration of more personal connotations and emotional responses that were evoked when working with these individuals.

Key themes were developed from the data collected via audio recordings, later transcribed, and notes were extracted and highlighted using thematic analysis. Through my training as a child and adolescent psychotherapist I was developing the capacity to explore and gain an understanding of the motives of human behaviour, feelings and emotions, whilst paying particular attention to detailed observations within interactions. I considered these skills to be unique in developing an increased understanding of the exchanges within the research process itself, as well as upon data analysis. I hoped that the findings would be illuminating to the network, the local authority and CAMHS service, increasing their, as well as my own, comprehension of the challenges and difficulties faced when engaging with these young people.

A unique aspect of this research study is that data was collected from two different perspectives of providing care and interacting with unaccompanied minors. To date there is little evidence within the literature reviewed that has used a similar research design in this subject area. These two facets of data collection offer a wider vision and contribute to a greater depth of knowledge regarding the challenges within the network.

## Context and statistics

The CAMHS clinic was situated in a densely populated city, with a large majority of white British citizens. There is an economic history to the area which has impacted on the sharp contrast of affluent and poorer areas of the town. At the time of data collection there was a big political driver for the UK to leave the EU and the locality was largely in favour of Brexit and closing the UK's borders to those trying to claim asylum. Not all the data collected in this research study was gathered from within the clinic setting, with some being collected in a small, urbanised village not far from the main city. Again, this was largely populated by white British individuals, 93% of whom were born in the UK, with the area being less densely populated and having a calmer pace (ONS, 2017 & 2019).

When considering the relevance of this research study it seemed important to explore the statistics regarding unaccompanied minors coming into the UK and living within the local area. It is important to point out that statistics are ever changing and those mentioned in this introduction were correct and relevant at the time the study was conducted. During this period unaccompanied minors were not located evenly across the country with higher numbers presenting in local authorities where there are access routes into the UK. An attempt was being made to manage the numbers of young people arriving in the city, comparing this to the overall population and transferring cases to neighbouring cities who had more capacity to accommodate them. A dispersal scheme had been introduced within the local authority a few months before the study commenced which impacted these statistics.

> *The National Transfer Scheme has been launched to encourage all local authorities to volunteer to support unaccompanied asylum-seeking children (UASC) so there is a more even distribution of caring responsibilities across the country. Under the scheme, a child arriving in one local authority area already under strain caring for unaccompanied asylum-seeking children may be transferred to another council with capacity* (Gov.uk, 2017).

There was a recognition that the numbers of unaccompanied young people were increasing and as a locality provision needed to improve in line with what was being offered by other councils. Since 2000 the locality had been a designated 'cluster' area in the south of England, originally set up to alleviate pressure on areas with a higher concentration of asylum seekers, such as London. As of the end of June 2016 two thirds of all unaccompanied minors (66%) were being placed in London and the South East, with a further 11% in the East of England (ADCS.org.uk). Between April 2016 to March 2017, the locality accommodated thirty-nine unaccompanied minors, predominantly from Albania and Kurdistan, with approximately seven of these being referred into the local CAMHS. From April 2017 to March 2018 the statistics showed there were sixty-eight unaccompanied minors looked after by the local authority, who were spread across neighbouring cities. Within the urbanized village there were eight foster carers who were accommodating eleven of these unaccompanied minors.

In January 2017 I could only gain access to statistics between June 2015 and June 2016, the subsequent years were still being calculated. Estimated figures from the Home Office showed that the UK had 36,465 asylum applications, including dependents (Gov.uk, 2017). This was

an increase of 41% compared to the pervious 12-month period with 3472 of these applications from unaccompanied minors, which was a 54% rise compared to the previous year and represented 10% of all main applications for asylum. Those granted asylum, or other forms of protection were 74%, compared to 67% from the year before. Children refused asylum were from countries where it was deemed safe by the Home Office for them to return to their families, others were determined to be above 18 years of age. At the end of September 2016, the figure for asylum applications pending further review was 4,729. Each one of these cases represents a person stuck living in limbo, anxiously awaiting news of their impending future.

Later in 2017 I was able to ascertain more recent statistics which showed that the overall number of asylum applications, including dependents had decreased by 14% to 26,350 with 8,555 of these granted asylum and of these only 2,774 were children under the age of eighteen. This was a reduction compared to 3,175 in 2016 and 3253 in 2015. As for the locality in which the research took place, it was one of the most densely populated cities in the UK with an approximate population of 240,00 in 2017 (ONS, 2019). A large proportion of the population were in favour of the Brexit campaign at the time and endorsed the proposed ideas of tighter restrictions of UK borders, restricting access to those wanting to reside from overseas [1].

In March 2016, unaccompanied minors represented 6% of the looked after children population (gov.uk, 2017). Under the Children Act 1989, support for these children is the responsibility of the local authority's social services, regardless of the child's immigration status. When a child starts to be looked after, their primary category of need is assessed. For unaccompanied asylum seeking minors, 91% have a primary need of absent parenting and 5% are looked after due to abuse or neglect (ADCS.org.uk). According to the National Institute for Health and Care Excellence (NICE) local authorities are expected to have a variety of placement options available. Options including foster care, residential care, special guardianship and adoption should be available and considered (nice.org.uk). Unaccompanied minors aged sixteen and seventeen are often placed in independent or semi-independent accommodation. This may include residential care supported by key workers, emergency use of bed and breakfast accommodation and supported hostels**.** The form of accommodation will have a considerable impact on an unaccompanied minor's safety, security, wellbeing and, potentially their future

[1] Precise figures and statistics of the locality are not documented to protect anonymity and to remain in accordance with ethical approval.

development. It has been suggested that foster care provides the greatest protection against mental illness (kpho.org.uk). A cross-sectional study by Sanchez-Cao et al. (2012) suggested that low-support living arrangements are a risk factor for psychological distress and behavioural difficulties in unaccompanied minors. However, ultimately, the experience of good foster care may also depend on how inclusive carers or families are. Sanchez-Cao also found that challenges experienced included cultural differences which can be barriers for social support even in foster care. This area will be explored further in the literature review.

**Outline of thesis**

The following thesis will explore literature in the areas of unaccompanied minors and their Mental Health, the professionals that work with them, how foster carers are impacted and their contribution to a role as caregiver, as well as some lasting thoughts stimulated from what I found interesting and noteworthy from particular texts.

The methodology will then provide an outline of the research design, ethical considerations, my political and religious stance, how the sample was recruited and where the research took place. Following on from this the methods of data collection will be explored, how the data was analysed, considerations regarding reflexivity and validity, and finally the limitations of the study overall.

Next in the findings and discussions chapter, key elements of the rich data collected will be explored and divided into two parts. The first exploring the availability of foster carers in providing care to unaccompanied minors and the boundaries put in place. Additionally, how being different played a part in the intricacies of their relationships. The second part will look at data gathered from professionals across 5 main themes, time, working with the unknown, difference and diversity, distance and connectedness, and responsibility.

Finally, the conclusion chapter will not only document my closing thoughts, but further discussion points from across both parts of the findings chapter. These will cover language and communication, trauma, and its impact upon ‘cold care’ and ‘unthinking racism’, and the impact of having gaps in knowledge and understanding.

# Literature Review

## Introduction and methodology

This chapter comprises a methodological review of the research conducted across three groups which are the main subjects of my investigation; unaccompanied minors, professionals that work with these young people (e.g., social workers, mental health professionals, paediatricians), and foster carers. The inclusion criteria for the literature explored within these three sub-sections related to the study's aim, which was to explore the challenges for the professional network of providing therapeutic support to unaccompanied minors and their perspectives on what challenges the young people themselves face, with a specific focus on trauma and mental health. There were five main methods I employed when reviewing literature. These were, 1. Using free text searching online, 2. Employing bibliography, and referencing list searching, 3. Conducting author searches, 4. Consultation with experts in the field for suggested and prominent literature, and 5. Online journal searches via EBSCO host, via the NHS Tavistock and Portman NHS Foundation Trust login (Shibboleth). For the latter, the 'Discovery' keyword search engine was used, inputting key words relating to the question using the approach of PICO which is commonly used for NHS medical journal searches (Patient, problem or population/ Intervention/ Comparison/ Outcome of interest). Key words such as *"unaccompanied asylum-seeking children"*, or *"separated children seeking asylum"*, or *"refugees"* or *"foster carers and UAMs"*, or *"UAMs and trauma"*, or *"working with trauma"* were utilised to explore academic journals and via free text searching online.

To refine the journal searches even further there was an exclusion criteria. Only full text, academic journals were selected, as well as focusing on research carried out in the UK. Some papers incorporating Scandinavian research in this area were delved into for comparison, as like the UK they operate in a welfare state system and have similarities in how they care for unaccompanied minors. Using these defined criteria helped to avoid becoming overwhelmed with journals, thus enabling assessment of the quality of the research itself. Additionally, literature referencing Looked After Children will be reviewed to note the disparities and commonalities between this group and unaccompanied minors, who become 'looked after' by the local authority and those they reside with (within foster placement or a residential placement for example). Psychoanalytic theory and research (such as projective identification, working with the unconscious and countertransference), will also be explored in this chapter to see what this perspective can bring to this specific area. Inevitably this will bring an

alternative perspective to the work and theories presented by social workers and medical professionals which largely dominate in this area of literature.

There was a need to be precise with the focus of this literature review due to the constraints of this thesis and the extensive and multiple dimensions of this area of research. An evaluation of this field highlighted what had been explored historically, how useful this was for my developing understanding of the research question, and the apparent gaps which this research study could perhaps lessen. A few of the most interesting research papers relevant to the inquiry warranted further exploration, and so will be explored in more depth.

**Unaccompanied Minors and their Mental Health**

Chase et al. (2020) comment on the use of institutional codes (UASC & UAM) used within social care, health, and education systems to distinguish unaccompanied minors from other young people, such as indigenous children, also differentiating them in immigration statistics (p.8). However, this can lend to notions being cultivated that assume all these young people are the same with instinctive shared experiences. Thus, *"there is a risk of over-essentialising young people's migratory experiences while overlooking the multiple other facets to their lives*". This potentially leading to "*reproducing tropes and stereotypes embedded within the bureaucratic labels used to categorise these young people"* (p.3).

Trauma experienced by unaccompanied minors may include conflict, starvation, and limited access to health care in their home country, physical violence, trafficking, female genital mutilation, sexual exploitation, and discrimination. This requires good access to primary and secondary care facilities including mental health services (ADCS.org.uk). Hughes (2014) paper helpfully illuminates the challenges facing refugees in accessing mental health services and support, as well as how much of this support predominantly focuses on their vulnerabilities and the effect this can have on those seeking help. However, *"This is modeled on western assumptions, which do not adequately take account of culture"* (p.139). Hughes describes a *"gulf"* between our western ideas of mental health and those of a refugee community, which can make initial engagement challenging. Language barriers also make it much harder to find out about and access services available. A lack of knowledge and stigma combined with cultural inappropriateness of mental health support make it exceedingly difficult for refugee communities to get the support they need from services (p.141).

Chase et al. (2020) also highlight how systems (Asylum, Immigration, and Social Care), ascribe an 'inscribed vulnerability' to unaccompanied young people which can bring several problems. This suggests that a certain type of 'vulnerability' needs to be demonstrated to be deemed eligible for support. Butler (2009) explores the precarity within economic and social institutions which exacerbates these vulnerabilities, which are inevitably politically induced (p.2). Through this lens unaccompanied young people either become viewed as 'vulnerable victims' who 'deserve refuge', or 'abusers' of the asylum system who are seeking for a better life and claiming things that are not rightfully theirs. This reduces their individuality and dehumanizes them. Thus, practitioners and researchers alike need to be mindful of their roles as *"contributors to the ways in which the 'refugee' child or young person is framed, presented and analysed in public, political and policy discourses"* (Chase, et al., 2020, p.2).

A research journal from the *Department of Social Policy and Intervention* (Bronstein, et al. 2012), explores PTSD (Post Traumatic Stress Disorder) in asylum seeking male adolescents, the largest group of children seeking asylum in the UK at that time. Two hundred and twenty-two participants completed self-reported screening measures for traumatic events experienced in their home countries and PTSD symptomology,

providing quantitative data for analysis. It highlighted stressful life events (see Table 1) that motivated minors to leave or be sent away from Afghanistan, with loss of a loved one being the highest. An interesting finding from this study was that although just over one third of young people reported clinical levels of post-traumatic stress, the majority did not. Despite exposure to several adversities a substantial number of these young people were doing well, suggesting a certain level of resilience. This perhaps indicates a gap in their research and a need for a resilience-based approach exploring the variation of outcome to similar risk experiences. However, this does helpfully reinforce the notion that not all those who experience conditions of adversity will develop maladaptive outcomes (Masten, 2001; Rutter, 2007; Bronstein, et al. 2012).

Table 1

| **Stressful Life Events as reported by Afghan UASC** | **%** |
|---|---|
| Sexual maltreatment | 5% |
| Serious accident | 33% |
| Life threatening medical problem | 34% |
| Drastic changes in the family | 47% |
| Disaster | 54% |
| Other not mentioned event (witnessed) | 60% |
| Separation from parents | 61% |
| Witnessing physical maltreatment | 65% |
| Personally being physically maltreated | 67% |
| War or armed conflict | 71% |
| Other not mentioned event (self-experience) | 79% |
| Loss of loved one | 80% |

An earlier paper written in 2004 by Thomas, et al. combines a retrospective as well as current study of Social Services case files, legal statements, and semi-structured in-depth interviews with 100 unaccompanied minors. The purpose was to collect information about pre-flight experiences of unaccompanied minors coming to the UK, and to increase understanding and support needed upon their arrival. As with the study of 2012 discussed above, the most prominent finding was that some form of violence was the main motive for flight in almost all cases (prominently involving a family member). Rape as a weapon of war is sadly not a new phenomenon, but this study highlighted that it was not only girls who were victims of sexual violence. Several boys reported they were either sexually violated or raped before leaving their country of origin, or on their journey to the UK. Again, this paper highlighted how easy it can be to take the typical western stance of stereotyping refugee children as *"unwell"* without having a thorough understanding of their experiences and the cultural ways they may react to these experiences. Their recommendation was for services to strive towards obtaining this understanding to provide *"adequate, appropriate and sensitive care"*. Helpfully yet painfully, to bring this to life vignettes of the young people's accounts of their experiences were included. This refreshing example was one of few qualitative studies I came across in the sea of quantitative research and data analysis.

The traumatic loss of an adolescent's home and family has an intensely disintegrating impact upon their internal world and their process of identity formation. Melzak et al (2018) highlights Akhtar's (1999) concept of 'cultural dislocation' when considering the consequences of multiple and overwhelming impingements through the process of becoming an enforced migrant (p.328). Consequently, the ordinary course of adolescent psychological maturation, with its recapitulation and progression, instead become ruptured and fractured. Repeated separations and losses spike primitive anxieties, a 'fear of annihilation' (Winnicott, 1960) and an attack on linking as an endeavor to try and grip onto psychic survival. As an alternative to being held, intolerable emotions are fragmented into pieces and disconnected from so they cannot grow into conscious thoughts and become associated with emotion. Melzak, et al. further emphasize that to connect with these would be felt too deadly, so they become sterile and lifeless. Thus, their emotions and thinking lack in creativity which can impact upon learning and relationships (p.328). Their first and foremost basic need then from those who are given the role of caring for these individuals, is a consistent and reliable base. From here they can begin to trust in their basic physical and emotional safety again (p.334).

Stability is a critical component for the development of identity. It permits us not only to create an experience of a world as we see and understand it, but to also enable an individual to find their place and function within it. Yet, there are some that do not have an experience of 'good-enough mothering' and are not able to have an idea of going on being (Winnicott, 1964, Melzak et al, 2018). Papadopoulos (2002) highlights the importance of 'home' in our psychical lives, adding that refugees suffer a range of traumas, but what they share is a total loss of this sense of home, which is made up of family environment, place, country, language, and geography. When faced with this loss an individual can become focused upon one source of their unhappiness and this may be a physical medical symptom. An important illusion has been shattered, the notion that one has a safe and secure place where one belongs that is inviolable.

There is an abundance of psychoanalytic knowledge and theoretical literature concerning children in care. Rocco-Briggs (2008) states how most *"looked after children suffer traumatic and abusive experiences at the hands of their parents, which leave them emotionally damaged, and full of painful feelings that their parents have not been able to help them process"* (p.191). Pain is consequently expressed through distorted forms of verbal and non-verbal behaviour. Thus, it is not surprising that there is a high percentage of looked after children with specific mental health difficulties expressed through delinquent behaviour, specific attachment difficulties and aggression (p.191). This may ring true also for unaccompanied minors when bearing in mind additional language barriers.

An idealised image of the looked after child's family and relationships may be held by the child who is unable to see their parents as abusive or negligent. Problematic and negative interactions thus occur and stay within the relationships with carers and other professionals, rather than within the child's birth families (Rocco-Briggs, 2008). Fagan (2011) suggests that when there is a loss of an experience of containment, the here and now of the present world collapses and the child is catapulted back into the world where s/he came from; defenses are reinstated (p.141). For an unaccompanied minor, the family they have lost or left behind may remain continually active and alive in their mind, thus making it harder for them to adapt into 'family life' of foster care. Akin to this, grievances that may lie with their birth family and that have been unresolved due to migration, may play out within their current network consciously or not so. This will be further explored in the following sections of this review (Sirriyeh, 2013a, for example).

Henry's (1974) [2] work on double deprivation highlights how a child and/or young person can employ crippling defenses to protect themselves from the horrific external circumstances they have been exposed to, over which they have had no control (p.16). These defenses that have once served to protect the child now prevent them from being able to absorb more positive and helpful external resources available to them. Spince (2000) describes how looked after children project aspects of their turmoil into their network in immensely powerful ways, as they do with their therapist. Britton (2005) reinforces this with thoughts of how unconscious processes influence professionals' responses and the intensity (or lack of it) provoked in a case. He suggests that *"severely deprived children are in contact with professionals and carers who re-act to them in a way that repeats the child's own unspoken dynamics within his own family"* (p.52). Emanuel's (2006) chapter on 'Triple Deprivation' explores this further. Confusion and anxiety that cannot be verbalised nor tolerated by the child are projected out into others and clouds the environment prohibiting access to them. Social workers, for example, may appear disorganised with shifting states of paralysis from the conflicting emotional demands, or may seem hyper-busy with no space available for thinking; parallel to that of the child who has no space to digest their own painful experiences (p.240).

Another concept of interest that appeared when exploring this group was 'Time'. It was highlighted in the British Medical Journal (Bains, et al. 2018) how a presentation of symptoms needed to be one month after a traumatic event to receive treatment. Furthermore, additional support would be required if symptoms lasted *"more than four weeks, or for those presenting with severe symptoms within four weeks of symptom onset"* (p.2). Indicators highlighted were, re-experiencing nightmares/flashbacks/intrusive memories, avoidance symptoms, hyperarousal or excessive concern/alertness to danger and threat, all of which have a significant impact upon an individual's daily functioning. Complex PTSD was also explored, and treatment of a phased approach (stabilisation, trauma processing and reintegration) was specified. What was unique and helpful about this medical document, in addition to highlighting a gap in research/observation, was the evaluation of a service user who had lived through the experiences outlined. They expressed the importance of forming trusting relationships which ultimately could allow a patient to speak about their experiences and symptomology. Interestingly, this paper also offered advice on how to structure a *"10-minute*

[2] Also know by her married name Williams in later years.

*consultation"* with this cohort of individuals to get information to either diagnose, prescribe treatment, or sign post to alternative agencies. Thus, the construct of time was highlighted again and left the question of how one could build a trusting clinician-patient relationship to identify PTSD symptoms within a 10-minute appointment? The paper itself did not address this contradiction.

Time as a concept was also noted by Sanchez-Cao, et al (2012). This quantitative paper studied depression and PTSD symptoms in seventy-one unaccompanied minors living in London via self-reported questionnaires. It also explored their access and engagement with Mental Health Services. It found that,

> *depressive symptoms rather than post-traumatic symptoms best predicted service contact indicating that many with emotional distress, particularly post-traumatic symptoms, failed to have contact. This may be because depressive symptoms, e.g., tearfulness or social withdrawal, are more visible to foster carers and social workers, and perhaps also associated with poorer social function, e.g., poorer scholastic attainment, and so result in referral to MHS. Post-traumatic stress symptoms may [also] not be [as] visible…* (p.657).

It may be that depressive symptoms were also easier for foster carers and professionals to identify and respond to due to the difficulty of hearing and being in touch with the 'trauma' part of PTSD.

Researchers considered how stability in placement and time required before emotional exploration, understanding or observation of an individual's difficulties could occur, as another potential explanation for the lack of mental health involvement. What this study lacked was follow up interviews or discussion with their participants which could have allowed researchers to seek further clarification of their results. Instead, there were several hypotheses generated without much foundation and without any evidence from the network around these young people. The study also seemed to be created and analysed with a 'western-lens' with no evidence about these young people's contact with services prior to coming into the UK. However, what this paper helpfully recognised was the importance of considering depression alongside PTSD and highlighted more training requirements for professionals to support unaccompanied minors to identify their needs and to access Mental Health Services. What it failed to comment on was how foster carers could play a part in this and be further supported with additional training. As it is not made explicit the reader is left assuming foster carers have

not been considered, or that they have been cast under the sweeping umbrella categorisation of 'professional'.

A presentation given by Lowe *'The psychic pain of minorities'* (2016) made me curious about transgenerational trauma, how unaccompanied minors place themselves in society, as well as where 'we' place them. His work illuminates internal racism and the links to outward projections onto others if not owned by an individual. Hughes (2014), drawing on the previous work by Hoffman conducted in the 1990s, had the opinion that, *"we view the world through our own unique set of 'lenses', shaped by our specific experiences, and consequently are selective in what we attend to in our interactions with other people and our environment"* (p.143). Even the work of Freud (1930) 60 years prior to this highlights a similar view:

> *It is always possible to bind a number of people in love as long as there are others left over to receive the manifestations of their aggressiveness - the outsider may be different in only minor ways, but this will suffice* (p.77).

The experience of trauma and neglect and how these are responded to may not be consciously remembered, but behaviours and attitudes are affected by them, as well as the structure of the brain (Music, 2006). Behaviour patterns established early in life can be difficult to shift once an experience is burnt into the amygdala, the seat of our primitive fear responses (p.49). However, therapeutic work can enhance such processes, interpreting experience in a new and less frightening way; promoting better thinking capacities, greater ability to form a narrative about oneself and to form and manage attachments (p.50). Fagan (2011) discusses the importance of psychotherapy with looked after children and how retrospectively establishing a good object cannot undo the bad earlier experiences, but that one new attachment can facilitate another. However, this can be daunting for a child who is terrified of the new possibility of intimacy and who clings to the fantasy of self-reliance. Thus, this inhibits the straightforward development of new relationships (p.130).

Martin's (2012) journal article is one of few with a focus on unaccompanied minors using a qualitative approach. It incorporates and explores psychoanalytic theory and neuroscience, which are utilized to help understand how highly traumatic experiences, emotionally and cognitively unprocessed, may become expressed bodily. The aim was to gain a better understanding of the underlying cause of psychosomatic presentations which many medical

models are often unable to decipher. Martin helpfully highlights the contention *"between the medical model and the psychoanalytic one in terms of how we seek to explain the genesis and pathology of a condition"* (p.4). He explains that psychoanalytic writers will focus on the psychological factors in the causation of a disease based on an individual case, whereas employing a medical model focuses more on an empirical approach towards diagnosis with the hope of finding the underlying cause in the future. Many physicians accept that 'stress' plays a role but are unwilling to go any deeper. It is suggested that different approaches, (emotional, psychological, physiological, and sociological aspects of illness) need to be integrated with both an inwards look to the biological workings of the body, as well as outwards to the wider context of the family, culture and society (p.5).

The sense of 'going on being' is employed to understand the compromising position an individual finds themselves in when a "*hole"* in their narrative is opened, but quickly needs to be patched up to maintain some level of integrity and to evade terrifying, unthinkable anxiety (Winnicott, 1962). Martin goes on to explain how there is then a failure to develop an integrated sense of the self-situated in the body (p.6). The main argument explored using two extensive case studies,

> *is that in situations of trauma, there is an absence of the capacity for negation. Experience is not represented per se, not experienced in mind and therefore not repressed. Rather, at this level, trauma may be felt bodily and 'remembered' bodily* (p.6).

Martin concludes an important aspect of the work with refugee and asylum-seeking families is the recognition of the wider context of their traumatic experiences and how this relates to their experiences of dislocation from a cultural context. Home and safety are not just about a physical place, but a sense of security, identity and a specific place in a chain of human connection (p.18).

Meltzer's (1967) map of the psychoanalytic process is utilized by Melzak et al. (2018) in their journal article to track the therapeutic phases of their work with unaccompanied minors and refugees. In its original form this theory underpins the evolution of naturally developing transference via reliable and regular therapeutic containment in the search for truth (Meltzer, 1967, p.12). Further exploration of these key phases appears to correlate with an unaccompanied minor's transition from a chaotic and traumatic journey into a residential environment, for example, such as into foster care and how this is tolerated and processed:

- *Disorientation in time and space – overwhelm (flight/flight) versus frozen blankness (corresponding to Meltzer's sorting of geographical and zonal confusions)*
- *Conscious seeking of a new secure base – evoking unbearable longing and grief (corresponding to Meltzer's gathering of the transference)*
- *Facing vulnerability and fear*
- *Experiencing rage and hatred, and concern for the damage they can do (corresponding to Meltzer's threshold of the depressive position)*
- *Tolerating uncertainty and separation in intimate relationships (corresponding to Meltzer's definition of the weaning process)*

(Melzak et al, 2018, p.335)

Melzak et al (2018), write about their work within the Baobab Centre. They aim to offer individual emotional containment as well as collective containment with a sense of belonging through therapeutic groups and community activities. 'Community' is significant to the young people they work with and recognized by the organization which addresses a young person's need for belonging and feeling known and cared about. They also highlight the impact upon the process of identity formation when both homeland and family are lost in traumatic circumstances. This is further impacted by young people being left in situations of limbo, for sometimes years at a time, waiting to be granted leave to remain status. *"The experience of waiting impacts on their capacity to mourn what has been lost from their childhood and adolescence, and most significantly it interferes with their capacity to develop a secure sense of their identity in their new country"* (p.327).

They also bring to the centre of our thinking what an unaccompanied minor may have left behind. People, places, daily routines, smells, sounds and tastes of life as they knew it are often left behind them quickly, without time to prepare and full of fear. They may have been well educated, had ambitions to work in certain positions or started certain career pathways. Sadly, their forthcoming contact with agencies in the UK compounds their experience of displacement from their identity with incorrectly spelt names which follow them and assigned birth dates. Melzak et al (2018) suggests these are, "*bureaucratic attempts to place an individual, to situate them, perhaps as a way to manage the horrendous feelings of dislocation and lack of place experienced by these young people on arrival in the UK"* (p.329). Research conducted by

Chase (2013) emphasizes how the uncertainty surrounding the futures of minors seeking asylum alone in the UK has social and economic consequences, as well as an impact upon their wellbeing. She further highlights how a sense of wellbeing is derived from felling in control of present and past aspects of their lives, in addition to feeling secure, integrated, with an anticipated sense of self in a future trajectory.

## Professionals within an unaccompanied minor's network

When considering professionals in the network around an unaccompanied minor, this review mainly explores that of health care (psychological and physical), medical and social care professionals. Of course, there are others, such as Government officials, lawyers and court officials, teachers, and council workers to name a few. Although these will not be explored in such depth, due to the practical limits of this thesis and what was immediately available from my searches, there will be themes explored and highlighted which may be relevant for these parts of the network. Additionally, it may highlight material which would be of benefit for them to consider in their work with unaccompanied minors and aid in developing an understanding of their interactions and relationships.

Roberts (2019a) considers how we are heavily influenced in our choice of profession, and consequently the networks, setting and client group we work with, by our need to work through and come to terms with unresolved issues from our past. Bion (1961) described this phenomenon as *'Valency'*. He highlighted how certain roles can attract staff with similar internal needs and defenses (unconscious to them), giving rise to collective defenses against the anxieties which become stirred up by the work, which can gravely hinder task performance (Roberts, 2019a, pp.127-130).

When considering roles within the care professions, two distinguishing features that differ from other professions are identified. First is the reparative nature of the work in relation to other human beings. "*This means the job situation often very closely resembles early-life situations that the worker may still unconsciously be dealing with, and which drew him or her to this particular line of work"* (p.133). The other is that of the self, which is felt to be a vital tool benefiting the client. Care professions are often regarded as vocations requiring special qualities. *"By offering themselves as such instruments, workers unconsciously hope to confirm*

*that they have sufficient internal goodness to repair damage in others. This is a source both of individual and organizational ideals, but also of much anxiety"* (Roberts, 2019a, p.133).

Robert's continues to accentuate how the capacity for empathy is important within a caring profession; *"to stand momentarily in the other's shoes and experience their pain, using what one has learned as a guide as to how best to respond".* However, this capacity can be compromised when there is a close resemblance between a worker's conflicted past experiences and their encounters at work. Sometimes an accentuation of difference, with the staff seen as the strong, sane, helping ones and the patients being the sick and deprived ones, is used to defend against these similarities. Interactions and tasks with patients may also become rigidly structured. However, on the opposing side differences may be denied and an identification with patients may occur with an overwhelming sense of pain and despondency felt by both. Both instances fail to facilitate an appropriate client-professional boundary (Roberts, 2019a, pp.134-135).

In England, social services across the country have a duty to deliver protection and care to unaccompanied young people from the moment th67ey enter the country. In recent years, research studies have identified several concerning practice and policy issues regarding their response to unaccompanied children. Mitchell's (2003) paper conducts a literature search exploring previous research, focusing on three main areas (1) the referral and assessment process, (2) the use of the child welfare legislative framework, and (3) issues arising from the provision of placements and other support offered to unaccompanied children (p.179). Evidence in all areas was identified as weak with little seeming to be known about the nature and context of the work carried out by social workers in response to this group of individuals. The evidence available suggested that young people's experiences of arrival and referral tended to be haphazard and at times unsupported. Assessments were described as problematic for several reasons, including language barriers, lack of resources to acquire background information about a young person, and a reluctance on their part to engage with a perceived person of authority. The overall conclusion indicated there was no empirical evidence to determine whether assessments were being completed or not, nor any evidence on their quality. The intense complexity of the work with this group of individuals was noted, as well as the additional skills required by social workers to carry out their work. The paper helpfully pulls together strands of care and support available at the time, connecting it to legislation which highlighted difficult areas, such as placement matching for example. However, it is out-dated

and does not provide any new evidence on the subject matter, just a historic standpoint mapping the problem rather than offering any further insight to it.

However, there are examples of papers which withstand the test of time and provide useful models relevant to the present day, such as Miller and Gwynne (1972). This paper refers to interactions with patients, but the two models of care they describe I feel are relevant when considering how unaccompanied minors are responded to and taken care of. The first providing care based on a 'warehousing' ideology, where physical needs predominate, and patients are treated as animals. The second is termed a 'horticultural' ideology, where a patient's unfulfilled potential is held at the center and their development as an individual is essential. Miller and Gwynne observed how professionals considered this second approach to be superior and it was difficult for them to see how it also failed some of their clients.

Roberts (2019b) highlights how there is often discussion about the need for better coordination, collaboration and for teamwork in organizations. However, services remain fragmented, competitive, and rivalrous and efforts to address these difficulties are often greeted with failure and frustration rather than success. Individual parts of a young person's care package will include multiple agencies. Thus, they may be involved with his or her GP, a paediatrician, social services, CAMHS professionals, teachers, a voluntary sector social club and other helping professionals.

> *Each agency deals with its own 'bit' of the client, and new problems are likely to lead to further referrals to yet other agencies. As the client passes from one agency to another, each can blame the others for any difficulties and the gaps that appear during transition* (p.164).

Melzak et al. (2018) outline the combination of the current 'hostile environment' in the UK, and a young person's trauma-induced defenses. Current policies in place,

> *deliberately prevent the linking up of services and systems in a coherent and helpful process around the refugee population… [This can merge] in a toxic way with a young person's trauma induced defenses, which might similarly attack any attempt to make meaningful links and piece together a coherent narrative to help them gradually process and make sense of their experience* (p.331).

Consequently, the development of meaningful relationships is prevented with others not wanting to connect with them, as well as halting any advancements in healthy emotional development and identity. As a result, professionals working closely with unaccompanied minors can become overwhelmed with maddening rage, helpless despair, confusion and anxiety, to name a few emotional states. Therefore, a desire to cut off from the unpleasantness of the experience, or to omnipotently take a liberating stance on behalf of the young person is evoked (p.332). This is in keeping with Henry's (1974)[3] theory of Double Deprivation. She defines the first level of deprivation as inflicted upon an individual by external circumstances over which they have no control. The second is a level of deprivation deriving from internal sources, where crippling defenses and poor-quality internal objects provide little support nor the capacity to form relationships with an internal object. The individual is also unable to make use of support offered to them externally. Emanuel (2006) builds upon this further to explain how the initial deprivation and neglect experienced by an individual can reverberate within the network of a looked after child, for example, and become acted out by professionals unconsciously due to the high levels of projections they experience. Defenses employed by the professional, such as attacks on linking, can interfere with their capacity to think clearly or make use of outside help, such as supervision or caseload management.

Kohli (2006) explores past reports and studies concerning the vulnerability and need of unaccompanied minors and the poor-quality services and practices that they have encountered. His aim was to examine these reports of inadequacy and position social work practice in a more optimistic light. Twenty-nine social workers from four different local authorities, in relation to thirty-four unaccompanied young people in their care, were interviewed. It was considered that what was lacking and underexplored in this area was evidence from social workers acting in a humanitarian way, forming relationships within which trust, and commitment were formed. The participants were asked to tell a story of one young person they were working with, from the perspective of their own relationship with the young person and their work with them more generally. The stories were then examined to highlight how and if their accounts illuminated their engagement with the young person's past, present and future world. Then, how their insight of these worlds assisted resettlement.

[3] Also refer to Williams (2002)

This research highlighted that these professionals mostly worked within and across three 'domains' of practice. The domain of ‘Cohesion’ where assistance was given to meet practical needs and ensure their daily lives were functional and orderly. ‘Connection’, forming an understanding of their emotional worlds by containing and organizing a young person’s memory of past experiences. Finally, ‘Coherence’ where the young person and the social worker co-constructed a fresh start in the UK, based on an adaptable and stable relationship where they had come to like the young person.

The first set of social workers fell into a category named *“the humanitarians”* where their interventions reflected the practical assistance they offered. The next were referred to as *“the witnesses”.* They were able to connect with the emotional challenges of the young people they worked with, supporting connections of the past and present. When this became too much, they would often resort back to a ‘humanitarian’ position, a more distant and comfortable position of practical help. The latter was described as *“the confederates”* who described their work with and the young people themselves as interesting and elastic in their capacity to survive. They described resilience and expressed a fondness for and attachment to them, often dealing with dilemmas by taking a young person’s side and safeguarding their interests and needs.

Overall, the paper highlights how salvaging ordinariness out of extraordinary lives and to recognise what is familiar in strangers bears fruit over time. Trust is valued across all domains highlighted, and specific mention is given to the awareness of differences between enquiry and intrusion. To enable resettlement, bringing order, peace, and a sense of rhythm into ordinary life was deemed a vital role of social workers. Interestingly, this study focused on positive practise in that no participant shared an account of a negative or difficult relationship they had with an unaccompanied minor and I wondered if this left a gap in the study. From the outset the aim was to bring a different kind of focus to this cohort of professionals, thus little space was available for social workers to share an alternative perspective or opinion.

Rocco-Briggs (2008) explains how looked after children come into care with extremely disturbing experiences and therefore express worrying behavioural difficulties, which ultimately impact the professionals and carers responsible for their care. This also rings true with unaccompanied minors, although the trauma they have experienced is likely to vary to that of a looked after child and so what professionals encounter may feel unique. For either cohort a variety of feelings towards different individuals or in various contexts is

communicated unconsciously. One consequence of this may be that professionals may separately hold a range of opposing or disjointing feelings about the same child. A re-enactment of primitive mechanisms and defenses against these powerful projections into the system can become acted out by care professionals and carers creating a disorganised, flippant state of mind (Emanuel, 2006, p.239). In a caring profession, hatred or rejection towards clients is deemed unsavory, so these feelings are dealt with by projecting them onto outside agencies or outside groups, who can then be disparaged (Halton, 2019, p.14).

An individual's emotions which are too painful and threatening to bear can be defended against in various ways. Like an individual, an organization can also develop defenses against pressures too distressing to acknowledge. These may be external threats such as government policy or social change.

> *They may arise from internal conflicts between management and employees or between groups and departments in competition for resources. They may also arise from the nature of the work and the particular client group. [This] can obstruct contact with reality and in this way damage the staff and hinder the organization in fulfilling its task and in adapting to changing circumstances* (Halton, 2019, p.12).

Hoxter (1983) suggests how when working with looked after children, it is *"extremely difficult to continue to function as a thinking person with an ability to reflect upon feelings rather than to react to them"* (p.129). With a constant barrage of projections, they need to employ sufficient and useful defenses of their own, and are likely to become ill, withdrawn and entangled amongst the client's projective identification. *"When there is a lot of pain involved, a natural reaction is to attempt to avoid it"* and thus to understand or deal with what is being projected into them. "*In this situation, staff burn-out is also much more likely to become a problem".* Consequently, feelings of hopelessness and demoralization are felt by professionals which can lead to quitting roles altogether or trying to get rid of the pain by evading knowledge of it in themselves (Moylan, 2019, p.24).

> *It was likely that such intensely guilt-inducing feelings would often be deflected outwards and away from the work, in all probability finding their way into other parts of the institution, where they might well have adverse effects on working arrangements and interprofessional relationship* (p.81).

Melzak et al (2018), highlight the impact of increasingly hostile and punitive political attitudes towards refugees on the mental states of these young people, as well as on professionals' own levels of helplessness and despondency. Those working with refugees and asylum-seeking minors are faced with a disturbing paradox. There is growing recognition within health, social services and education, both of psychological and emotional needs, which has emerged from attachment theory, developments in neuroscience and more trauma-aware services. Whilst conversely, legal and governmental frameworks encompassing immigration and asylum can be hostile, lengthy, and expensive, thus resulting in a highly destructive and disruptive period of waiting in limbo which can be painful (p.327). With much of this being outside of the control of the young person waiting and those around them in their support system, Mawson (2019) emphasizes how for many *"the chief anxiety which needs to be contained is the experience of inadequacy"* (p.83). Professionals need to cultivate defenses in order to cope, of which some can promote development, creativity and growth. Others can be the same as the clients as they become caught up in projective identification and so they find themselves operating in similar ways (Moylan, 2019, p.25).

> *Within organizations, it is often easier to ascribe a staff member's behaviour to personal problems than it is to discover the link with institutional dynamics. This link can be made using the psychoanalytic concept of projective identification. This term refers to an unconscious inter-personal interaction in which the recipients of a projection react to it in such a way that their own feelings are affected: they unconsciously identify with the projected feelings* (Halton, 2019, p.16).

Working and being in a group can often be powerful and overwhelming. There can be tension between wanting to join collectively and wishing to be separate; between the need for closeness and belonging, and the need for a distinct and independent identity (Stokes, 2019a). Halton (2019) highlights how use of psychoanalytic understanding in an organisational setting can create a space where it's members can have time to stop and consider the emotional processes they are involved in, which can lead to a reduction in stress and conflict and inform development and change within the organisation. Communication between individuals and within groups requires someone who can hear and correctly understand the message. Too often, we are only able to hear what we anticipate hearing. Alternatively, we hear what we are comfortable with, and edit out the rest.

Moylan (2019) considers how the 'listener's' own experience should be the centre of their attention when working with trauma, or countertransference as a narrative is revealed:

> *This conveys the essence of the trauma, how painful it was to be there, and can make it possible to discover the exact nature of the pain. The capacity to hear the message accurately requires the ability to pay attention to all aspects of one's experience* (p.20).

However, Mosse and Roberts (2019) highlight the anxieties of annihilation, fragmentation, and threat to survival this can stir in the listener and the traumatised individual themselves. For those who pose the story and those that can bear to listen and empathically feel it, there is often a want to withdraw from reality. This can seriously compromise the capacity of problem-solving. Mosse and Roberts state that there is often an interplay of different threats,

> [some from the outside,] *as when an organization is at risk of closure or of being taken over. Others come from within, in the form of threats to self-esteem or to group cohesiveness…If anxiety can be contained, then what needs to be talked about can be named, and some effectiveness recovered. Sometimes the threat itself can be overcome. Even when this does not happen, it is possible to regain some inner sense of having the power to affect one's own experience, rather than being a silenced victim* (pp.162-163).

A specific theory mentioned in many journals and papers identified in this literature search, was 'Containment' as developed by Bion (1962). He introduced this concept using the example of the mother-infant relationship. There is emphasis on the importance of the mother, in the early months, attempting to notice, understand and attend to her young baby's non-verbal and unconscious communication of discomfort, fear and anxiety. Depending on the mother's psychological strength and sensitivity, through trial and error, and learning from this experience the infant's primitive anxieties are reduced. This theory of containment is the essence of what is described previously, the professional remaining open to thought when faced with projected emotions in their raw and confusing form, whilst remaining open to thought as they learn to understand and build a relationship with an unaccompanied minor. The development of such a relationship in adolescence, for example, may be daunting and even feel threatening to some young people. Being given what has been missed, lost or denied can hold consequences and painful reactions and links to past traumatic events so that a young person

may feel less inclined and open to forming such relationships. This can prove a challenge for some professionals who may take this kind of response personally.

Youell's (2019) paper identifies the valuable contribution of psychoanalytic therapy and understanding in the work of a multi-disciplinary team around an unaccompanied minor. Many services follow treatment guidelines recommended in NICE (National Institute for Clinical Excellence) when providing treatment to unaccompanied minors. Psychoanalytic one to one work in many services forms a small part of this, with EMDR (Eye Movement Desensitization and Reprocessing) and group-based activities, for example, being more prevalent (p.168). Holding in mind what has been explored previously regarding projections from and into a network, Youell highlights how many of these interventions are employed with hope and plans based on the future, with the request from one professional to another to help a young person *"work through"* or *"come to terms"* with painful material. An alternative standpoint from professionals is to take flight from the emotional pain present by becoming overly active with matters such as education or housing. Good communication within a network is encouraged within this paper, with clear boundaries accentuated regarding what everyone is doing in their area of trained and paid expertise. Confusion about parameters of roles leaves little hope for a young person to be able to make sense of what they are being offered.

Youell accentuates that three key psychoanalytic elements of a therapeutic encounter (containment, transference and counter transference) are relevant not only in the consulting room, but in a school lesson, home visit, meeting or even an encounter on the street. *"Listening to words, observing the non-verbal presentation and being open to the emotional temperature [are] vital component[s] of any interaction with a young person, whatever the setting and whatever the role of the professional"* (p.176).

Being prepared to wait, to bear pain without a rush to thinking of the future, to tolerate the unknown, and not make demands are important in allowing a young person to feel that their experiences (internally and externally) have been understood. Forming relationships with this ethos *"…will offer these young people the best hope of recovery"* (pp.178-179). A quote from Salzberger-Wittenberg (1970, p.163) further illustrates this,

> *The caseworker may not be able to pick up on the most pressing anxieties of the client at any particular moment in time. What is essential to the client is the caseworker's willingness to try to understand how he feels, to be prepared to listen and respect him as a unique personality. Her actions, as well as her words, will show whether she is*

*really concerned about him and in touch with the adult and infantile parts of his personality and whether she has the courage and integrity to face the emotional pain.*

Again, in the literature explored relating to professionals, and specifically in this paper, the theme of time appears. The work of Garland (2002) accentuates the importance of timing and timescales. The offer of therapeutic intervention may be refused or resisted if offered too early or too forcefully. Additionally, an individual should be seen not as a member of a uniform population but as an individual with their own responses to trauma. Time is required to get to know them, their qualities, and personal experiences (Youell, 2019, p.169). Time boundaries of an intervention itself is also integral to define how a therapeutic relationship differs to others it may be compared to, such as to a social worker for example. This may be incredibly pertinent to a young person who may come from a culture where they have not had any previous experience of therapy or counselling, and where mental health, anxiety and depression does not have a vocabulary.

Konistan's (2017) research paper was one of very few which explored the impact of secondary traumatic stress on professionals who work more generally with traumatized individuals. There were no examples which focused on the impact of secondary trauma stress on professionals from their work specifically with unaccompanied minors, an area which obviously requires further investigation and thought. Within this specific paper 210 professional staff within the area of London (working in hospitals and private clinics) completed four self-reported questionnaires which measured their secondary traumatic stress. The paper helpful highlights how the term secondary traumatic stress is used loosely and interchangeably with other terms such as vicarious traumatisation, countertransference, compassion fatigue and burnout. Each were identified separately and then their relationship to secondary traumatic stress. As set out in the paper itself, I have divided each term using bullet points.

- Vicarious Traumatisation

According to McCann and Pearlman (1990) vicarious trauma refers to harmful changes that occur in a professional's view of themselves, others and the world as a result of exposure to the traumatic matter of patients. The changes that take place in the therapist's cognition are relentless, increasing and permanent. Konistan clarifies that vicarious traumatisation changes the cognitive schema of an individual, whereas secondary trauma stress refers to a set of psychological reactions that mimic PTSD. This can also be an outcome of exposure to traumatic material (pp.60-61).

- Countertransference

The term countertransference derives from psychoanalytic theory. Freud (1910/1957) wrote, *"we have begun to consider the counter-transference, which arises in the physician as a result of the patient's influence on his unconscious feelings"* (p.289). Herman (1992) regarded the concept of traumatic countertransference as like secondary traumatic stress. Opposing this, Figley (1995) distinguished countertransference from secondary traumatic stress suggesting the latter involves but is not restricted to countertransference which takes place within psychotherapy. Further, secondary trauma stress is a natural outcome of caring, and a relationship between two people where one has gone through a traumatic event whilst the other is affected by their material. Konistan (2017) also highlights that secondary trauma includes characteristics such as changes to values, beliefs and behaviours or trauma workers, and that countertransference can take place outside of the exposure to trauma, whereas secondary traumatic stress always develops as a result of exposure to traumatic experiences (p.61).

- Compassion Fatigue

Compassion fatigue was first identified by Joinson (1992) to describe nurses who were suffering from 'burnout' due to the prolonged daily demands of their work in emergency rooms. Compassion fatigue was understood to be the outcome of regular work with traumatised individuals when offering an empathic approach. Consequently, it was coined as a 'friendly used term' for professionals who suffered from secondary traumatic stress (Figley 1995, p.14). White and Gumley (2009) highlighted the difference between secondary traumatic stress and compassion fatigue, insinuating that in secondary traumatic stress there was the presence of PTSD symptoms, whereas compassion fatigue was the result of exposure to trauma amalgamated with empathy for patients.

- Burnout

Baird and Kracen's (2006) research suggested that professionals require a defence response to persistent contact with insistent interpersonal situations which produce psychological strain, known as Burnout. Contrasting to secondary traumatic stress and compassion fatigue, much of the mental burden from burnout is related to the organisation where an individual works to include frustration caused from unattaining goals, work stressors such as administration, paperwork, and management pressures and restrictions. Konistan highlights Webster and Hackett (1999) research into burnout among clinical staff members in community mental

health agencies. This concluded that burnout was connected to leadership behaviour and supervision quality provided by an employees' clinical supervisors.

Within the context of secondary traumatisation, another term notable in Konistan's paper is 'shared trauma' or 'shared traumatic reality'. This is when the professional and those they are helping experience the same disaster. Thus, the professional is exposed to the primary (involvement in the event) and secondary trauma (listening to the material expressed by the patient) (p.70).

The results from Konistan's study revealed that many professionals working with traumatised individuals displayed symptoms related to secondary traumatic stress, in particular those newer to their role. This work had an impact on them both mentally and physically. Interestingly there was a larger reduction in symptoms the longer an individual had been in their profession. Konistan suggested years of experience may help professions to employ resiliency against severe traumatic events. However, it does not explore an opposing position, that the longer an individual is in their role exposed to such trauma, the more they could become emotionally disconnected and removed from what they are confronted with. Dissociation and potential emotional numbness may occur as a form of self-preservation when it becomes too much. Another interesting finding from this paper was that females were inclined to experience higher secondary traumatic stress symptoms compared to males, regardless of years of experience. No further remarks or speculations are made to understand this or to suggest why this might be so.

The paper ends on a helpful note, suggesting further training for professionals about secondary trauma and its impact is paramount to ensure the well-being of individuals that do such a job. Undoubtably useful data was collected via the questionnaires completed, but again this is another example of a paper lacking in additional investigations to gain clarity and understanding of the data itself, thus the conclusions drawn remain limited.

**Foster Carers: their contribution and how they are impacted**

There is minimal up-to-date information regarding the quantity of unaccompanied minors in UK foster placements. Mitchell (2003) documents that 60% of unaccompanied asylum-seeking children in the care system were in foster placements at the time of their study. National shortage of foster carers was a familiar report during this literature search, with local authorities often depending on independent fostering companies, affecting not only the location and cost of placements available, but resulting in young people being far away from their local authority. This also impacted upon the ease of contact with allocated social workers and the foster carer's

relationship with and support received from social care. Some social care providers reported extensive measures put in place to 'family match', placing unaccompanied minors with a family with similar religious beliefs, ethnic or cultural background. Williamson (1998) noted that some local authorities invested substantial resources into recruiting carers from refugee communities and in some cases achieved in a close match of children and families from the same village of origin. However, this was some time ago and considering the gradual rise in numbers of unaccompanied minors coming into the country since then, there was nothing evident in this literature search to suggest this had been maintained.

There appears to be little written on how supporting foster carers with a space to think about how a young person in their care can have a positive impact upon the placement stability and increase understanding of behaviours and promote relationships. This is something that in practice I witness often. An example of a study that does explore this area, but not with unaccompanied minors specifically, is by Donachy (2017). This paper investigates the impact stress and trauma has upon foster placement stability and a carers loss of their sense of self, both of which appear pertinent and relevant when applied to looking after unaccompanied minors and so warrants a deeper evaluation.

Six foster carers who had ended a placement with a child under the age of five were interviewed. All these children had experiences of early abuse and neglect and the study argues how attempting to care for these children led to an internal shift in the carers, often reverberated throughout the network around the child. Donachy considered knowing the external reasons of the placement breakdown was not enough without contemplating the impact on the internal world of the foster carers, as well as the trauma these children often brought with them into placement (p.223). Interpretative Phenomenological Analysis (IPA) was used to analyse the data from the semi-structured interviews to understand human experience and relationships, as well as allowing the exploration of emotional and internal experience. Numerous helpful theories and concepts were highlighted to accentuate the intricate interplay within the foster carer - foster child dynamic. These included loss of a sense of self, splitting, reflective functioning, identification with a maltreating parent, confusion and bewilderment, and feelings of helplessness when living with trauma.

Good and bad parts of the child were often kept far apart, with examples of names such as 'monster' and 'angel' used by the foster carers to illustrate behaviours and how this in-turn

made the foster carers feel. These were kept widely apart and Donachy felt the sudden switch between the two had a deeply unsettling and *"foundation-shaking effect on the carers"* (p.224). Fonagy et al. (1991) noted the significance of the interpersonal nature of the reflective self, emphasizing the importance of sensitive and attuned parenting. These ideas stemming from psychoanalytic literature helpfully describe the internal mental process which not only affect an individual's behaviour, but how they behave within relationships. *"Parental reflective functioning is a key aspect of the sensitive caregiving role and promotes not only the child's development, but also his growing capacity to conceive of others' mental spaces"* (Donachy, 2017, p.229).

Akin to other research papers, projections (feelings that are mirrored between the carer and the child) were mentioned as a key component by which trauma was replayed within relationships, often that which the child has first-hand experience of or had to witness. This linked to the expressed feeling of losing one's sense of self. Foster carers in the study expressed how they felt like the depriving or maltreated parent which the foster child had expected them to be. This was unbearable for them and the exact opposite of why they had taken on their role as carers; to provide care, love, and protection. Foster carers in the study had started their caring journey with positive feelings but these were overshadowed with hopelessness, defeat, despair and not knowing what to do for the best. Helplessness and the feeling of being without control is an experience common to trauma. Donachy employs Freud's theory of the 'danger situation' (1935) to clarify the recognized, remembered and expected situation of trauma which evokes immense anxiety and helplessness. This loss of association with encouraging feelings expressed by the foster carers were grouped into themes such as, interruption to ordinary life, embarrassment/discomfort, impossible demands on time, heart-breaking, the need to get away, being vigilant/on edge, and shocking/disturbing.

Although this study has a small sample size and does not refer directly to unaccompanied minors, it does helpfully highlight the usefulness of vignettes to bring the data to life. It also concludes that foster carers in general need to be helped to explore and let go of their unhelpful defenses when faced with the above adversities and complexities. An important part of recruitment into such a role and training there forth, should incorporate preparation for feelings of *"uncertainty, confusion, disconnection from the child and possibly oneself"* (p.240). Overall, it helpfully summarizes,

> *...that the experience of providing care for children with a background of abuse, neglect and trauma had a significant unsettling impact on the internal worlds of the foster parents and the children's social workers, including examples of secondary trauma, loss and disturbances of personal and professional identity, leading to a loss of the sense of self. The experience of living with uncertainty, and with conflicting feelings, was ultimately unbearable. The study has thrown light on the way in which the internal parental objects the children bring with them can cause conflict and anxiety in the carers, which they need help to think about* (p.239).

During my literature search there were minimal examples that effectively explored the experience from a foster carer position when looking after unaccompanied minors. Two I came across that were particularly illuminating, and I wish to explore further were by Sirriyeh (2013a) & Sidery (2019). Sirriyeh discussed findings from case studies and focus groups with unaccompanied young people and foster carers providing their care across 4 local authorities in England. Two theoretical elements familiar within social work practise, 'Family practices' (Morgan, 1996) and 'Hospitality' (Derrida, 2000) were helpfully surveyed when considering the encounters and negotiations within the foster home environment and the relationships formed within them.

Rees & Pithouse (2008, p.339) defined foster care as 'the coming together of strangers' where each individual has to build and learn new ways of understanding and exhibiting intimacy within a limited time span. This coupled with uncertainty about what the future holds can be emotionally distressing for young refugees. Building on Morgan's construct, Finch (2007) describes how new family members must grasp becoming included in existing family practises, but also co-create new ones. To be successful family practises they must be understood by other members as possessing meaning coupled with "family".

Sirriyeh (2013a) draws on Derrida's work to further explore how foster carers and their families can also be considered as 'host families' offering hospitality to young people who enter into their homes. "*'Hosting' implies an offer of hospitality from those who own or control a territory that is entered to the newcomers who cross the threshold"*. Yet, the concept of hospitality possesses an innate tension with *"a shared etymological route of the words 'hospitality' and 'hostility'"* (p.6). In extending hospitality, hosts claim control of the household. Guests are unable to 'make themselves at home' completely as this could disrupt the host's order and

control of the household (Sirriyeh, 2013b). This positioning of host and guest makes it difficult to extend absolute (unconditional) hospitality.

Eliciting these ideas, the study determined relationships from the accounts they analysed fell into three models, 'like-family', 'guest' and 'lodger'. 'Like-family' was described as a young person and foster carers forming new 'like-family' connections, adopting titles like 'mum', 'auntie' and 'son', or descriptions such as 'like a mum', 'like a brother'. Like-family status were exemplified via the production and display of photographs of young people with their foster families. Often these relationships would endure further than the end of the placement because of the tight bonds.

'Guest' was explained as there being respect and value between the foster carers and young people, but no tight bond. Common interests are absent with divergent lifestyles. Little time is spent together, thus a close knowledge of each other was not constructed. Relationships were time limited until the completion of the placement. Finally, 'lodger' was where relationships between young people and foster carers were distant and had a degree of tension. Foster carers felt they were only able to deliver the service they 'were contracted to provide' and consequently young people did not have a sense of belonging.

This paper effectively summarises that foster carers identified the need to be flexible in their organisation and control of the household, incorporating a young person's food practises and celebrating their cultural traditions within existing family food and cultural practises. Having curiosity about and seeking to find out the young person's interests and organising family social activities around these was considered valuable. It was deemed unhelpful for carers to expect young people to adapt into existing households without having something of themselves inserted into the family constellation and manners. Challenges in placements emphasised a difference in opinion between foster carers and young people. Foster carers highlighted concerns about age disputes and asylum claims, whereas young people felt more concerned about their status of being in care and the perception of foster carers' motivations.

Sirriyeh helpfully explores differences between looked after and unaccompanied minors, emphasising that in contrast to indigenous young people in foster care, refugee young people experience transition and settlement into new homes entwined with a wider process of arrival and transition into life in a new country. They transport with them not only their life in another family and household, but a life in another country, often where there is conflict, violence, and chaos. A refugee's first placement can be within hours of their entrance into the UK.

While making helpful contributions to this area, the study has its shortcomings. All refugees who took part in this study were male, and the foster carers only reported on male foster placements, thus a female perspective is lacking. Furthermore, the data that was gathered and divided into helpful themes had no further unravelling to understand the processes at play, something I found myself wanting more of.

Sidery (2019) takes another social work perspective, understanding and learning from the experiences and views of foster carers looking after unaccompanied minors. From this they endeavoured to inform the development of effective carer training and support. A qualitative method of semi-structured interviews was used to allow foster carers to raise and discuss themes they saw as relevant to the questions asked. Eight interviews were conducted with eleven foster carers (three married couples and the rest were individually interviewed). They were recruited from multiple fostering agencies in one semi-rural county in the South West of England, with a considerably lower ethnic diversity than the national average. Thematic analysis was utilised to identify themes from transcripts that felt important to the carers. Vignettes brought the foster carers to life in the paper which reinforced the findings from Sidery's analysed data. The geographic nature of this study, the method of analysis and the use of vignettes was refreshing and offered a different perspective into the material.

Fear of the unknown, risk, as well as negative attitudes and suspicion of family members and those in the local community were apparent. The following vignette powerfully identified this:

> *[Cath:] "Maybe it's because I was a single carer, I was a bit frightened of the unknown, not having come across Muslims at all to be honest. Where I live there isn't a mixed culture. So … it's sort of the unknown isn't it a little bit. But I would definitely have one again."*

*Initially, when she had provided respite for an unaccompanied young person for the first time, one of her relatives had expressed concern:*

> *Cath: "She was particularly concerned about my safety. Now you see, but that again, I was a single carer having a foreign person, a refugee … how do I …"*
>
> *Interviewer: "Was she concerned about your safety in terms of fostering generally? As in, you could have young people with quite complex backgrounds."*

*Cath: "No…"*

*Interviewer: "So, it was something to do with the unknown aspect…"*

*Cath: "It was the unknown of having a refugee. Yeah. Definitely. And that is fear of the unknown, isn't it? Luckily, he was such a presentable young man, everyone who met him …"*

To evade the feeling of 'the unknown' and lack of control, the foster carers identified 5 main resources they predominantly accessed for support, the internet, referring to support organisations, seeking out contacts in the local community, speaking to social workers, and using the support of other foster carers.

Sidery (2019) also highlights the benefits suggested by Taylor and Soni (2017) of providing a space for discussion about fears and concerns, rather than avoiding conversations about risk-related topic areas, such as radicalisation, thus reducing the fear and feelings of lack of expertise and control. Sidery further expands on how fostering unaccompanied minors is like 'signing up' for a different kind of task to general fostering. There were different needs stressed and a sense of 'otherness' reflected in the narrative of the foster carers accounts. Cultural needs, including religion and food, adjusting to life in England (new currency, education system, etc.), communication needs including language barriers, advocacy and accessing services, and needs pertaining to the asylum-seeking process (such as recovery from trauma, emotional support, practical assistance to attend appointments, etc.).

A key finding from the study was that foster carers wanted training to be conducted by those with relevant expertise, such as individuals who work with asylum-seekers, foster carers who had long term experience of fostering this group of individuals, and those who had supported them with experiences such as legal processes. A need for more training for those in the network was also identified. Social workers were considered often having contradictory and incorrect assumptions of needs with a lack of a lead professional in a team with specialist knowledge in the area. Foster carers also felt they wanted more support with practical issues such as, assisting young people in learning English, how to open bank accounts, and how to provide emotional support following Home Office interviews, for example.

Drawing on past research from Linowitz and Boothby, (1988), Kidane (2001), and Ní Raghallaigh & Sirriyeh (2014), Sidery concludes that *"barriers to understanding must be*

*overcome"* with training courses needing vast improvement to reduce these, minimising risk of misinterpretation and misconceptions of a young person's needs and improved awareness about their journeys and experiences. Facilitating discussion around cultural expectations was also viewed as being crucial. Psychoanalytic interpretations were absent from this paper and rich material shedding light on the complex nature of fostering felt stunted.

Bion's (1959 & 1962) theories on learning from experience and the three drives/impulses of emotional relationships I feel is pertinent here, especially when considering the impact of and response to the 'unknown' qualities within the relationships between unaccompanied minors and foster carers. He describes three impulses which consist of Hate (H), Love (L), and to Know (K), that is the curiosity and interest to know about something or someone. He describes these as innate drives and internal instructions which attempt to explain what is happening to us and what is going on in the moment. However, (K) can become overpowered by intense feelings such as fear and anxiety. He goes on to explain the attacks towards (K) states of mind by the intrusion of (H), for example, spoiling the drive of curiosity which he defined as (-K). Being in a state where you are unable to think or know what is happening to you or around you can generate fear and utilisation of language, which is dominated by blame, thus becoming overshadowed by anxiety. It is only natural then to dissipate these unpleasurable feelings outside of ones-self and onto others, which is not purely a conscious process. This may also occur as a defence mechanism employed against the development of feelings of (L) and (H) and a lack of desire to want to know about these more (Maiello, 2000, Bambrough & Allnutt, 2020). Bion uses the term 'Alpha Function' to describe the transition of raw data into meaningful integrated experiences, usually through the process of projective identification. Failure of the Alpha Function leads to the accumulation of 'Beta Elements', defined as unprocessed emotions, thoughts and experiences.

Another gap in the literature available during my search was the little to no evidence exploring the impact of secondary trauma or compassion fatigue on foster carers who look after unaccompanied minors. One example I did come across was by Hannah & Woolgar (2018), but this explored fostering in general. In a study with 131 foster carers who completed an online survey with self-report measures, the impact of compassion fatigue on the caring role was investigated. It examines the links between secondary trauma, burnout, and compassion satisfaction on the commitment to continue fostering and overall job fulfilment. The study also looked at the correlation of compassion fatigue with two cognitive processes, thought suppression and psychological inflexibility, both of which Hannah and Woolgar identify as

being related to symptoms of avoidance in trauma (p.630). Psychological flexibility is explained by Hayes, et al. (2006, p.7) as *"the ability to fully contact the present moment and the thoughts and feelings it contains without needless defence".* Wegner et al. (1987) defines thought suppression as a conscious attempt to halt thinking about a specific thought. The ironic effect of thought suppression and the evading of undesirable internal experiences over time heightens and maintains the frequency of such unwanted experiences.

The conclusions drawn highlighted the psychological impact of working with traumatised children upon foster carers (Compassion Fatigue, Secondary Trauma Stress, Burnout and Compassion Satisfaction). This was remarkably similar to Konistan's (2017) research exploring secondary trauma stress upon professionals working with traumatised victims, mentioned earlier in this review. Hannah and Woolgar also identified that high compassion fatigue related to a lowered commitment to fostering and lower job satisfaction, an important finding for social care to note. However, this research identifies investigations exploring the overall well-being of foster carers is currently limited. Foster carers also highlighted, like the afore mentioned article, the limited training available to them and feeling acutely unsupported. The addition of a qualitative approach to this study may have allowed further investigation into the potential influences driving the participation and responses of the participants.

Fraiberg et al (1975) eloquently presents how unprocessed parental trauma can intrude in a new relationship with a child. Her work focused on supporting mothers to become aware of how their own trauma or 'un-mourned ghosts' could obstruct successful parenting, often leading to significant symptomology in their infants. Fraiberg's hypothesis was that if a parent has access to the pains and loses of their past in a thoughtful and reflective manner, then the ghosts of the past are less likely to intrude into present relationships with their offspring. Using a similar theoretical model 40 years later, Donachy (2017) considers how a form of parental trauma emerges for foster carers too, who have often had cumulative losses of previous children and young people in their care, as well as their own personal ghosts. This feels of value when considering what foster carers themselves unconsciously bring to the relationship with an unaccompanied minor who is living in their home.

When considering boundaries and barriers operational within networks and professional-client relationships, funding and finances is another to consider. Looked after children and unaccompanied minors are left without parents who are responsible for them and sometimes can lack understanding of a young person's emotional turmoil and pain. Instead, they have

adults who are paid to look after and work with them. This is a disconnected and removed position away from their pain and turmoil (Rocco-Briggs, 2008, p.195). Stokes (2019b) likens a delicate and unpredictable organization to inadequate foster parents, rather than it being a second home. Unavoidable feelings of hostility and envy towards parental objects (previously managers), are either denied or targeted elsewhere, promoting personal stress in the organization. Stokes compares this process *"to the somatisation of internal conflict"*. When we cannot cope with conflict at a mental level, it is repressed down into the body and expressed via physical grievances,

> *Unless the management of organizations is sufficiently stable to be able to provide a clear definition of purpose and a reliable container for the inevitably ambivalent feelings of those they employ towards those in authority, then the organization will express its disorder through individual and interpersonal disorder in its members* (Stokes, 2019b, p.143).

Threats to survival generate extreme anxiety. A common defense in groups against a perceived threat is to attempt to strengthen the emotional ties which bind them together. This consist of denying any discrepancies which could contribute to the disintegration of the group. *"It is at such times that one is most likely to find groups under the sway of basic assumptions"*. There can be an enormous unconscious pressure on members to blur differences, as if *"safety lies only in oneness"* (Mosse & Roberts, 2019, p.158-159).

**Summary of lasting thoughts**

Overall, it is evident that professionals have a role and an identity which enables a sense of protection in their work with unaccompanied young people. Whether this be defenses against the projections they receive, or a shield from the traumatic stories they hear and are made to witness, both allow them to function in their roles and offer procedures to address stress. Being viewed as figures of authority and conforming to such identifications further exemplifies this. It sets them apart from foster carers who, although sometimes classed under the 'professional umbrella', welcome these young people into their homes and so from the offset have different boundaries which open them up to receiving things in a vastly different way to that of social workers, medical staff or therapists. Their protective stances and shields are employed differently, thus they are impacted in a unique way, as I have previously drawn attention to.

It is a life-long reality that looked after and adopted children, as well as their carers' and parents, will be affected in unpredictable ways by their earlier experiences. Eruptions of behaviours or reactions to separation, for example, within relationships may be hard to comprehend when there is patchy knowledge of the child's early history and an absence of ordinary family memories (Rustin, 1999). I feel that this is not dissimilar to experiences of unaccompanied minors. In both cases with a looked after child and an unaccompanied minor separated from their family and familiar social and cultural contexts, there will be inconsistencies and distortions which make it hard for trust to be established from both sides of the relationship being cultivated. It may be that a therapist, a social worker or foster carer, is the first in that young person's life, or the first in a long while, to provide certain environmental essentials (Winnicott, 1949).

With this notion of trust in mind, I was also mindful of the media influence and documentation that was extensively cited online and on TV which I was frequently bombarded with during this literature search. I feel it important to briefly mention this here. The media have a long-standing history and powerful position in influencing how refugees are seen within society, thus impacting upon how their own identities may be formed. Hughes (2014) describes how the mainstream British media is, *"full of negative stereotypes of refugees, and provide a poor choice of descriptions by which refugee children growing up here in Britain can develop their identities"* (p.142). Foucault (1980) describes how social discourses shape our relationships with one another and the rules that we make govern social behavior. If these discourses are then negative, then the structures of society that form respond to these perceptions. Stokes (2019b) emphasises how anxieties about certain choices, such as sexual behaviours, feeding habits or socially sanctioned enemies, are reduced when one's actions are "*prescribed by a religious text".* This conjures reassurance and stability, reliability and familiarity. However, the dilemma comes as an *"out-group to fight against"* is required, which can incite a counterattack.

> *Whilst this may have been a tenable method of managing things in the past, particularly where the 'enemy' was always at some distance and less likely to be provoked, the increasing interdependency between nations and the rapidity of communications means that it is now a much less viable form of psychological defence* (p.139).

Keval (2005) builds upon Bion's (1962) theories of learning from experience when describing the process of psychoanalysis and how the "*acquisition of knowledge has a special significance, in the sense that our capacity to comprehend and relate to reality is thought to be intimately connected with our emotional development"* (p.32). When offering a therapeutic space, a triangular situation is encouraged (where one's own thoughts and feelings can be discussed with another individual) and it is determined whether an individual's "*mental space will expand with curiosity or contract if the anxiety that links give rise to is too intolerable"* (p.34). He adds that preoccupations with understanding our anxieties impacts upon our quality of thinking and obstructs the desire to learn and obtain intelligence about ourselves in relation to others in the world. "*Visible sign[s] of difference can upset an inner equilibrium by triggering unconscious anxieties"* and potential conflicts within the self become threatening. He uses an example of a therapist with different skin colour to the patient being a *"minor yet salient difference"* which is enough to trigger underlying anxieties to do with the prospect of change and development (p.33). Thinking about these differences, for example, requires a risk in learning from the experience which incorporates uncertainty, as well as keeping links alive in one's mind to develop collaboration and establish curiosity and creativity in thinking and practice. The opposing possibility is to seek 'psychic retreat' and disregard any knowledge that is foreign or uncomfortable (pp.40-41).

This literature review highlighted that there were few papers which explored both foster carer and professional's experiences combined in a qualitative manner. There is also extraordinarily little research conducted in the UK to date which looks at the impact on the mental health of professionals that work with unaccompanied minors. Similarly, there is also a lack of research with a specific focus on secondary trauma stress, or symptoms alike, of professionals that work with these young people. The literature was more generalised and considered 'victims and survivors of trauma' generically. Also noteworthy was that many of the studies focused on unaccompanied minors in the UK were carried out with Afghan males, as this was the highest population and gender group coming into the country at the time. Although there were other studies exploring the mental health needs and complexities of unaccompanied minors from other nationalities, many of these studies had been conducted in countries outside of the UK and thus were excluded from this literature search.

There were some specific papers that wanted to explore the good practice of particular professional groups, such as *"The Comfort of Stranger's"* by Kohli (2006). To some degree

this was a refreshing read from the incessant reporting of service failure, and flawed, struggling systems. However, interestingly like the papers that took a more negative stance, they highlighted how hard it is for professionals/foster carers to stay with and explore the difficulties and negative responses evoked when working with this cohort and the trauma present within relationships. The desire and later action to escape, evade and leave employment and positions was a familiar response to manage, for self-preservation and ultimately survival when interacting closely with these young people. Sadly, very little was documented about supporting professionals and foster carers through these difficult times and how addressing negatives thoughts and attributes could enable them to understand and observe their work through a different and more perceptive lens. This identified a gap to which I hope my research offers an alternative stance, which will subsequently be analysed in the chapters to come.

This review also highlights several papers where similar methodologies to those I intend to employ have been effectively used with foster carers and professionals. The next chapter outlines and evaluates the methodology I used in this research.

## Methodology

I began brainstorming my initial ideas about unaccompanied minors and their relationships with CAMHS in November 2016. My thoughts at the time centred upon the brief interventions I had had with these young people clinically, but also accounts I had heard or conversations I had been party to during meetings or case discussions. I was struck by the notion from some that the presentation of these young people was not connected to their 'mental health', but rather what they were exhibiting was to be expected and proportionate to what they had experienced in their home countries and during their journeys to the UK. It felt paradoxical then that the young people whose referrals were accepted into the service were treated with medication and with limited access to 1:1 work or groups. I wanted to investigate what was going on within the networks around these young people that might stimulate such responses.

As my first brainstorm shows (Appendix I), some of my initial thoughts were about, xenophobia, young people becoming lost within a system and within themselves, language barriers and communication restrictions, differences in culture and a lack of knowledge provoking anxiety, as well as ethics and consent. My thoughts encouraged me to begin conversations with team leads within CAMHS, as well as the head of service. I also arranged an initial meeting with Social Care and the lead of the Looked After Children (LAC) service to find out their thoughts and concerns regarding this cohort of individuals.

With the latter I explored what was already on offer to unaccompanied minors in the locality and presented my initial interests, thoughts, and ideas of what I wanted to explore. I was able to discuss how and where psychoanalytic thinking could be useful in this area, with this group of young people, as well as their foster carers. It felt important to draw their attention to the unconscious processes underlying human behaviour, responses, relationships, and emotions and, additionally, how a protected space encouraging free associative conversations could provoke thought and creativity to grow and develop. This was very positively received by Social Care.

The main research objective was to find out more about the impact working with unaccompanied minors had on those living with and supporting unaccompanied minors (foster carers), as well as those working with them (professionals). The concerted aim was to explore the challenges of providing therapeutic support expected from both roles. All too often negative attributes and associations of providing support to and looking after unaccompanied minors are reported in literature, with statistics and accounts presented but not further unpicked or

understood. As was explored in the literature review, there have been recent shifts in research to investigate the positives to counteract this negative stance. However, I felt it was important to understand these challenges and difficulties to facilitate better support and care for unaccompanied minors, rather than just highlight and document them without further exploration of why these challenges present. I wanted to examine how working through these difficulties may be of benefit to the foster carers and professionals, and potentially their relationships with these young people also.

I was also interested to find out more about individual perceptions of the number of unaccompanied minors coming into the city and the impact professionals felt this had on the community itself and the services they were able to provide, or not. An additional interest of mine was to explore the impression of individual's working in the area, how they felt unaccompanied minors were regarded and if there were any similarities or differences to indigenous looked after children.

## Research Design

This study was conducted within a qualitative interpretative framework, attentive to the search for meaning through analysis of the data collated, instead of quantifying it. The research was thus constructed to develop theory and see how existing theories could aid in understanding the data, rather than solely relying on testing pre-existing hypotheses or principles. Two main methods were employed, semi-structured interviews and support groups. I hoped to conduct interviews with approximately six professionals, such as CAMHS clinicians and social workers, for example. To be included in the study professionals needed previous or current experience working directly with unaccompanied minors, and a good level of written and spoken English. The interview questions were designed to be open, allowing exploration of their varied experiences (Appendix II). Nine questions with specific prompts were asked across a thirty to sixty minute period, depending on the depth of conversation and responses. Participants were asked for their consent to audio record these interviews, understanding these would be deleted following a brief transcription of key responses. This alleviated the pressure of noting down all that was said and enabled engagement in the conversations.

As a researcher my epistemological approach fitted best under the "Critical realist/contextualist" method summarised by Terry et al. (2017),

> *...reality is 'out there' but access to it is always mediated by sociocultural meanings, and, in the case of qualitative analysis, the participants' and the researcher's*

> *interpretative resources (so direct access to reality is never possible). People's words provide access to their particular version of reality; research produces interpretations of this reality* (p.21).

Furthermore, my research question aimed to gain an *"understanding of participants' experiences as lived realities that are produced, and exist, within broader social contexts"* (ibid. p.21). The quality of the data, its richness and complexity on a given topic, allows for deep and delicate insights to be drawn out via thematic analysis, which is appropriate for both the analysis of interview data and support group transcripts. Akin to Keval's (2005, p.42) description of the interaction between a therapist and the patient in psychotherapy, I wanted to create a triangular space, rather than a dyadic space (them and me), in which the participants could begin to observe their own thinking and feelings and encouraged to engage with their more challenging issues and concerns rather than evade them.

It feels pertinent to mention some helpful advice given to me at the very start of this research process by a colleague. *"When raising the profile of your work and research, consider what you are being asked to do, for what purpose and for whose benefit".* I held this in mind through the research process to ensure what I designed and conducted was in fitting with my aims and not a consequence of organisational imperatives or alternative drivers or targets, especially when considering the internal politics and contentions within departments when the study did not match their national drivers or plans. It also highlighted what I could bring to this area with my specific training, knowledge and skill set, and consequently to a network's understanding of the challenges they were tackling.

**Ethical Considerations**

This study was approved by UEL/Tavistock and Portman in September 2017. The University Research Ethics Committee then gave their endorsement in November 2017 (UREC 1718 13). The Health Research Authority (HRA) granted their approval (IRAS 227148) along with the local NHS Trust Research and Development team (SR/002/18) in February 2018. The process of recruitment then began.

Although the afore mentioned paints a picture of a linear and smooth journey to obtain ethical approval, the process was far from that. There was considerable toing and froing between organizations with a lack of joined up thinking, mixed communication, and long periods of waiting for clearance. Some forms, abbreviations and terms felt confusing and alien which led

to me doubting my determination and strength to master the process, one which I felt lost within without formal direction at times. I could not help but consider and question the potential parallels, even at this early stage of the research process, with the challenges surrounding an unaccompanied minor's attempt to navigate through support offered, language barriers and the legalities of various systems and organizations.

A participation information sheet and consent form were sent to foster carers and professionals selected to take part in advance of their participation. A signed copy was required before either the support groups or the interviews took place (Appendix III & IV). The nature of the study as well as terms of consent and data storage, for example, were outlined in these documents and participants were made aware that withdrawal of consent could occur up until the data was anonymized and analysis had begun. It was then deemed problematic to decipher what data had come from whom. When signing the consent forms participants were also made aware that direct quotes may be used, and that the research may be published at a later date.

Due to the small sample size limitations of anonymity and confidentiality were highlighted to participants prior to the research beginning also via the information sheet and consent form. Brannen (1988), highlights how respondents can easily identify themselves and others close to them because the data collected via interviews is distinctive and personal. Thus, as a researcher I had a responsibility to protect and respect what was disclosed and the emotions aroused and expressed, along with holding in mind how identification may carry an element of risk of sanction or stigma from various sources (p.553). Kitzinger (2000) suggests that other research participants may compromise the usual confidentiality of a research setting, thus care should be taken especially when working with "captive" populations (such as patients attending a clinic or in a hospice). Nevertheless, there should not be the assumption that groups are always more constraining than the discretion of 1:1interviews, for example, or that they are unsuitable when researching sensitive topics (p.22).

I also considered how safeguarding issues could be discussed and concerns raised if necessary. Depending on the information shared and the degree of risk or safeguarding concern, it was agreed I would either discuss in my work supervision sessions, raise it with the Trusts safeguarding team, and/or contact the local Social Care safeguarding team and discuss with the allocated social worker. Participants were reminded of this process, confidentiality, and consent at the start of their involvement in person and during the research process. A risk

assessment was also completed to identify the potential risks to me which was approved in May 2017.

There was a possibility that some of the discussions in the support groups may stir uncomfortable and upsetting topics perhaps causing distress to the individuals taking part. There was a space given within the group to discuss and think about this, as well as further support which could be sought after the session via a 1:1 appointment in person or across the phone. Chase et al. (2020), discuss the positionalities of researcher and participant and how this can be shaped by contextual power subtleties. Although the researcher may possess the most control and power in the research situation in many ways, "*research participants can also exercise power in complex ways through forms of resistance or remaining silent, becoming angry or questioning our position as researchers"* (p.22).

I was able to use my weekly service supervision to discuss the research process and its impact upon me, as well as during group supervision within research seminars at my training institution. Laslett and Rapoport (1975) and Brannen (1988) suggest how interviews can be distressing for the interviewer as well as the interviewees and that close attention needs to be paid to the feelings evoked within the interviewer, especially those topics that may be threatening or worrying. Brannen notes that the stress generated by interviewing participants in depth and ways of managing this have largely been overlooked,

> *Researchers who are entrusted with the confidences of their respondents ought to be protected by some of the safeguards that customary are associated with the role of the confidant. Confiding is normally a reciprocal process. Each professional confidents – counsellors and psychotherapists – have their own confessors* (p.562).

All written information about staff and carer participants, including session notes, transcripts, and meeting notes, were anonymised. Children mentioned, and the staff and foster carers who took part are either referred to by their professional titles rather than by name, or their identities coded. I was responsible for the secure storage of the process notes after group sessions, the audio-recordings, and the typed transcripts, ensuring that all this data was kept protected in an encrypted file on a password protected computer and/or within a locked filing cabinet. This data will be stored for five years and then destroyed.

Finally, in keeping with Chase et al, (2020) thoughts of the ethical process, I did not want to exclusively view ethics as an institutionalised, 'tick box' process within academia and its permissions for research. I wanted to have in mind throughout the research process, in all its parts, reflections of my own positionality when exploring the potential marginalisation and discrimination that might became apparent in conversations within the support groups and interviews (p.3 & p.23).

**Political and Religious Stance**

Both political and religious themes run though this thesis and appear within the data itself, thus it feels imperative to state my stance as the main researcher and consider any personal bias in this area. I am a white British female and although do not practise any religion, I have an interest in developing my understanding and knowledge in this area, from a theoretical perspective and from those who practice a faith.

I consider democracy to be an essential right for individuals, that people have a voice they can feel free to express and have heard, thoughts which are considered, and experiences which are shared and felt by others. However, I appreciate this is not something that many of the young people referred to within this research paper have ever experienced, nor do they often feel they have such rights due to oligarchy and/or dictatorships present in many of the countries where they were born or have resided. Although I believe in democracy, I also recognise that I do not always agree, nor share the views of those who are elected to act on behalf of the citizens of the United Kingdom. In particular, the recent legislation which has impacted upon those seeking asylum and refuge within this country.

I think it is also important to emphasise that at the time of recruitment and data collection there was a large amount of media attention on the political campaign for Brexit. There were also many conversations which highlighted the pros and cons of shutting borders and who should be allowed access to and residence in the UK. At the time of completing this thesis, the political stance had more of a focus on 'Black Lives Matter' and Britain's history of slavery, immigration, and colonialism. I feel it is important to note the historical context in relation to politics as it may impact upon how the findings and conclusions are interpreted and thought about by the reader, as well as to consider this myself as the researcher.

## Sample and Recruitment

A familiar sampling technique within qualitative research known as 'Purposeful Sampling' was used to recruit participants in this study. This allowed for the conscription of individuals who could provide in-depth and detailed information about the phenomenon under investigation. Potential participants were identified differently according to whether they were professionals or foster carers and so they will be described separately.

### Professionals:

Unaccompanied minors were regarded as looked after children (LAC) within the CAMHS service I was in. As much of my work at the time was within this team, I felt I had a good understanding of who currently and who had previously worked with this group. To ensure my assumptions were correct, I sent an email to the whole CAMHS service via my NHS secure email account. This provided information about the study, what it was intending to explore and asked for individuals to identify whether they had experience of working with unaccompanied minors which they would be interested in sharing. Within a week I received replies confirming my initial thoughts and three professionals agreed to take part (Art therapist, Consultant Psychiatrist, and Paediatric Mental Health Nurse). An information sheet and consent form were sent prior to us meeting allowing time to read through finer details of the study, form any questions or thoughts they had about it, understand their roles and responsibilities and confirm if they were able to fully commit to what was being asked of them. A date and time to conduct the interviews was either made in person or via email.

Professionals within Social Care were also contacted, with consent from their manager, and some professionals within the Looked After Children's Health Care team. Correspondence via email with Social Care presented me with a list of five social workers who were case holding unaccompanied minors and so met the criteria to be prospective interviewees. I sent an almost identical email to these individuals as I had to the CAMHS team, adding I would pursue these with a phone call within a fortnight. I knew from previous experience in my role, that responses to emails from external services such as Social Care, could take a while. I was also considerate of how it might feel to receive an email requesting their time, which was already pressured and limited within their professional roles.

I managed to speak to two social workers three weeks later who expressed an interest and agreed a time to meet in person to discuss the research and be interviewed. These meetings

were arranged to occur within the central offices where these professionals worked for their convenience and to slot in between other events of their working day. Unfortunately, these meetings never happened due to several cancellations and rescheduling. Cancellations were either due to sickness, unforeseen urgent meetings about or with a young person that required their attendance, or the meetings themselves were forgotten entirely. On one occasion I was greeted by a social worker who told me they needed to pop out quickly to see a young person around the corner. They insisted they would not be long, and I should wait. Fifty minutes later they had not returned and so I left. All these experiences contributed to feeling frustrated, rejected, unimportant and as if they saw the research as insignificant.

Perhaps this could suggest the difficultly some professionals have with being able to locate a time and space to stop and think about these young people and the work they do with them, as well as what they themselves bring to the work and the intricate relations between them. I speculated whether this pattern of disregard, mindlessness, and inattention may become enacted in their relationships with unaccompanied minors also. All of which will be explored further in the findings chapter.

Due to establishing links with Social Care and determining how I would recruit foster carers via them, a relationship with a family placement social worker (FPSW), who supported these carers, was cultivated. I deemed it would be helpful to gain some of their thoughts and experiences as part of the interview process and enquired about their interest in taking part. After reading the further information and the consent form, they agreed. Due to the distance between our localities, we agreed to hold the interview over the phone and a date and time was arranged.

Both mental and physical health assessments are a part of an unaccompanied minors' life whilst living in the UK. For this reason, I thought it would be helpful to gather a consultant paediatrician's experiences and impressions of working with them during initial screening appointments. This individual was contacted via a secure NHS email, to explore their links with the subject and their capacity to be able to commit to the interviewing process. This was met with an instant defensive stance and some refutation. The limits of time were highlighted and there was a question about my integrity and the research's authenticity. A request was made to the Trust by the professional to verify their knowledge of my research and my request of the professional's involvement. Contact with prospective interviewees was only made after

receiving ethical approval from the Trust, so their reply that they were unaware of my study was a complete shock to me. This study appeared to slip the Trust's observance, much like that of the social workers afore mentioned. This provoked feelings in me of invisibility, worthlessness, and irrelevance. The response from the Trust coinciding with the defensive disposition of the professional, made me wonder about the need to protect oneself from the subject matter I was trying to encourage engagement with. This response also highlights again Chase et al, formerly mentioned thoughts on the power exercised by participants. The journey of this recruitment process was proving just as informative and significant as I hoped the analysis of the data would be. After some further emails to clarify the legitimacy of my research within the Trust the consultant agreed to partake. I had intended to recruit six professionals to interview, hoping to attain a minimum of four. A total of five took part.

**Foster Carers:**

Posters were designed to be placed in the CAMHS waiting room for foster carers to see whilst waiting for appointments. They were also sent out electronically to members of the Social Care team to identify any foster carers that might find the support group of interest or beneficial. The lead professional for the LAC department within Social Care agreed to connect me with a FPSW who was supporting local foster carers with unaccompanied minors placed with them at the time. A total of eight foster carers were identified as meeting the criteria for the support group. With their consent I contact seven of them via phone to discuss the research, what it could offer them and what the expectations of them would be. Six individual foster carers agreed to take part, with the work commitments of their partners restricting their availability to be able to attend. Information sheets and consent forms were then sent via email and post, depending on individual preference. This process of recruitment was much smoother than that of the professionals and took only a few weeks to finalise.

A date was set to meet face to face in the location where the support group meetings were due to take place prior to them commencing, so the required documents could be returned, and any questions could be asked. Unprovoked, at this meeting the group began to think about key themes that came to their minds that they wanted a space to further explore (Appendix V).

## Setting

Different settings were used within this study to obtain the data depending on which participants I was engaging with; thus, they are divided into the two following sections.

**Professionals:**

Interviews with professionals were mainly carried out in person and within the workplace of the specific participant. It felt important that they felt comfortable to think about and share their thoughts and experiences in response to the questions being asked. Asking such questions in a work environment meant that the external environment helped to reinforce their roles and positions, rather than these being conducted in a more informal and unfamiliar setting, such as a conference room in a neutral building for example. One interview was conducted over the phone due to this specific participant's work schedule and our availability not matching for face-to-face contact. They spoke to me from their car which for them, as a family placement social worker, was their equivalent of a mobile office.

**Foster carers:**

Securing a setting for the foster carer support group was slightly more complicated. This research was considered by the service as an 'additional piece of work' and deemed non-essential to its daily running. Therefore, there was no financial aid for room bookings. Due to many of the group attendees living in a similar location at a distance from the CAMHS clinic, and their commitments to supporting the young people they were looking after, sessions held at the clinic were not practical. Thus, they needed to be held at a more convenient and amenable location, close to their homes so that attendance would be as regular as possible. Funds for travel to and from this location for myself and the co-facilitator were also not available, and so were self-funded.

It felt important to have a neutral yet familiar location so that there was some comfort for the foster carers in attending such a group. Some of the individuals in the support group knew each other and were also familiar with meeting their family placement social worker monthly at the local Sure Start centre. Thankfully, there were fortnightly slots available at this location and there was no fee. It felt important to ensure a different room was booked from what they were used to meeting in, to limit any pre-existing connotations with the environment. For consistency and continuity, a request for the same room, at the same time on the dates required was made. Unfortunately, this could not be achieved due to another predated booking. Instead, sessions one to four were held in one room and sessions five and six in another. Foster carers were informed of this arrangement at the start of the group sessions and were reminded again on week three and four. Mawson (2019) helpfully highlights how, "*Holding group meetings*

*on the same day and at the same time each week helps strengthen this sense of containment, as does ending the meetings on time"* (p.82).

The initial room on the first floor, was bright and airy with one entry/exit. For each session chairs were arranged in a circular fashion with a table at the centre. The windows were often open and there were times when the room was filled with the noise of the car park below, which either made it harder to hear participants, or filled the silent gaps in conversations and discussions. The second room, although maintaining the same degree of confidentiality and security, was much larger and had two points of access, also feeding off from the main reception. Foster carers brought their own refreshments each week as they felt necessary. Kitzinger (2000) suggests that sessions should be relaxed and set up in a comfortable setting with refreshments and participants sitting round in a circle to establish the right atmosphere (p.25).

## Methods of Data Collection

As mentioned, the aim of this study was to explore the challenges of providing therapeutic support to unaccompanied minors from both a professional and foster carer standpoint. I wanted to examine what my training, skillset and viewpoint as a Child and Adolescent Psychotherapist could add to this network's understanding of these challenges via the methods further described below. Each is explored independently to offer a rationale of why they are suited to the research's aim, as well as their limitations. Reflections will also be made on how my research experience compared or contrasted with the theoretical understanding of these methodological conceptions.

### Support Group:

I hoped to have between four to six foster carers attending the support groups who were accommodating unaccompanied minors and had a good level of written and spoken English. The aim was to hold six sessions fortnightly, each lasting sixty minutes, over a two-month period. Kitzinger (2000) recommends the ideal size of a group is from four to eight, with sessions lasting around one or two hours and ideally tape recorded and transcribed. Unprovoked in my first face to face meeting with the participants, they developed a list of themes prior to the group commencing which they expressed a desire to explore. Following on from this introductory session, the plan was to begin each session with a summary of the previous meeting and then allow the group to discuss these topics they had mutually agreed upon. Additionally, the group was encouraged to speak spontaneously about what came to mind

as their conversations developed, a process commonly known as free-association. The formation of this group and its ending was also something considered as the weeks progressed.

The sessions were audio recorded and transcribed in detail, and later analysed considering the patterns of ideas, thoughts and feelings which reoccurred. These were further explored and coded during data analysis. A *Psychotherapy Verbatim Transcription Guide* (Weloty, 2015) was read prior to writing the transcripts to ensure the format was in keeping with standards expected for such research, the later analysis, and then producing this final document. There was an average of thirty-six pages per session, with the total number of pages of data reaching two hundred and eighteen.

Notes taken during and after these sessions helped to illustrate observations of the group dynamics, conversational themes, and countertransference material which included how it felt to be present as a researcher and at times also an active participant. These also acted as a reminder of the context of the conversations each week and ensured the raw data was the focus of analysis and not an interpretive stance. Another professional (a qualified Child and Adolescent Psychotherapist) who was attuned to this area of work was the Co-Facilitator. It was considered beneficial to have another active mind to support the thinking within this group and the nature of the material being discussed. The notes we made during the debrief period after each session helped us to consider how we each felt during and after the sessions and what was stirred within us both. This provided another dimension to the data being collected, as well as an opportunity to process the experience. An example of a few of these notes across each session are below:

> *"During the latter part of the session 'love' comes into my mind and I find myself questioning where is the love?!"*
>
> *"Establishing hierarchy in the group and I feel tested as they begin to have separate conversations which some of us are excluded from. I wonder if I should enforce something but am torn as I think about the rules and boundaries they agreed and this not being one of them".*
>
> *(Chief Investigator, 1st Group Session)*
>
> *"Eye lids feeling heavy, no back up from social workers and Asylum seekers portrayed at persecutory object"*
>
> *(Co-Facilitator, 1st Group session)*

*"Thoughts about religion and cultural clashes, what belongs to whom and in what way. How much can then be invested, and can they as foster carers offer this?"*

*"I felt told off at times, put in my place and useless"*

*(Chief Investigator, 2nd Group Session)*

*"The role of caring becomes a detective role and one of not knowing. You either deport or adopt them"*

*(Co-Facilitator, 3rd Group session)*

*"Spread of terror around the group which I speak to and they respond with trying to justify by presenting concrete examples. The session feels full of information and I find myself worrying if I have turned the tape recorders on; a worry if I can hold all of this and contain it"*

*(Chief Investigator, 3rd Group Session)*

*"Inflexibility in thinking by some members of the group today and some painful connections made aloud. A feeling of being unsafe and after the session I feel dizzy".*

*(Chief Investigator, 4th Group Session)*

*"A feeling after the session of things not shifting and there being lots of repetition. Discussed with [Co-Facilitator] who asked me what I was expecting to shift in this time frame. A reminder to me that this process was about creating a space to think and share in the premises of safety and trust. There is a web-like intricate structure of problems, ideas, conflicts and miscommunication with one leading back to another then back again"*

*(Chief Investigator, 5th Group Session)*

*"Unaccompanied minors and their foster carers all put into the same bag and treated as 2nd class citizens"*

*(Co-Facilitator, 6th Group session)*

*"Ending gives rise to feelings of being let down, forgotten, noticing what the challenges are and questioning what happens next"*

*(Chief Investigator, 6th Group Session)*

There is an important distinction between Focus groups and Support groups. Kitzinger (2000) describes focus groups as, *"a form of group interview that capitalises on communication between research participants in order to generate data"*, and as a helpful technique for exploring needs and attitudes (p.20). They also are driven by a specific topic to gain feedback and thoughts which may or may not be indicative of the general population. However, a Support group can be defined as a group of individuals with common experiences or apprehensions who offer each other encouragement, comfort, and advice. This type of group also has facilitators who offer input and space to think about subject matters that appear important to the group. Work within such a group can actively facilitate conversations of taboo topics with less inhibited members of the group breaking the ice for more timid members. Mutual support can be provided, with feelings expressed that are common to the group itself but that might stray from mainstream, or the assumed culture of the researcher. By analysing the operation of humour, harmony and disagreement within a support group and studying the variations of narratives employed, a researcher can identify shared and common knowledge (Hughes and Dumont, 1993).

Each foster carer brought something unique to the group, shaping its identity and the dynamics each time they met. It was of interest to note their individual characteristics which became prominent in the group, as well as how they used the space and one another each session. Consequently, these characteristics had an impact upon the data itself, as well as what they shared and how this combined with the overall dynamics. Within a group, members are likely to take up different roles, some of these will be self-elected and others an individual may be pushed into on behalf of the group. There may be positions of defensiveness, vocalisation on behalf of the whole group, of bravery and others which take on a more silent and passive role. It is also important to note that this group was an informal organisation compared to that of the interview participants who were more formal. The support group was perhaps more familiar and closer knit due to their prior connections within their fostering role, attending training and supervision groups with other foster carers in the local area before this group formed, for example.

What was noticeable, linking with Hughes and Dumont's (1993) definition of support groups, was the ability of some participants to break the ice for others and over time as they settled into their positions within the group, trust became established. This meant that taboo subjects could be shared even though they provoked feelings of shame and guilt, which could also be gradually consciously thought about. Furthermore, the foster carer support group did offer a sense of

encouragement, support and advice and allowed for knowledge to be shared regarding various topics, such as external services and resources as well as what had worked in the home environment in terms of setting boundaries, for example. A difference in opinion could also be thought about, although sometimes layered over with humour and jest as if to make it more palatable and acceptable. My position as a researcher within the support group as it progressed over the weeks, allowed me to take several different stances. Initially taking a *"structured eavesdropping"* position as highlighted by Powney (1998), progressing to a more interfering role to urge debate which otherwise might have naturally ended. I initiated further conversations about inconsistencies between participants and within their own thinking, as well as taking a devil's advocate position to provoke debate and encourage participants to further clarify why they think the way they do (Kitzinger, 2000, pp.25-26). As facilitators we cultivated a space for thinking and discussion, offering input and linking together ideas and concepts which participants sometimes missed.

**Interviews:**

Interviews were conducted with professionals who had been in their roles for many years, and they all had previous training in other professions related to their current post. The interviews took between forty-five minutes to one hour to conduct depending on the response from the individual participant and how much detail they wanted to go into and share. Each question had a various number of prompts to draw upon during the interviews if required. In all cases the interviewees appeared to have much to say about the topic and so it was rare that I had to employ these. In total, across the five interviews I made or asked forty-three sub-comments/questions. On average there were eight additional questions or comments per interview, with question two (*How they think their personal characteristics impact upon the work they do?*) and six (*Their perception of how many UAMs there are in the [local area]?*) stimulating most conversation and intrigue. The generated transcripts written from audio-recordings had an average of five pages per interview, with the total amount of data spanning across twenty-seven pages.

Semi-structured interviews with professionals were felt best suited to this group when considering the potential time constraints of their working day. They provided the opportunity to reflect upon and explore this specific topic in more depth when compared to a general conversation or survey, for example, and more flexibility for attendance when compared to a support group. Britten (2000) states that *"qualitative interviewing is a flexible and powerful*

*tool that can open up many new areas for research"* and are the most extensively used qualitative technique in health care settings. Their use can enable clinicians to investigate research questions directly relevant to their everyday working life, which might otherwise be problematic to investigate (p.18). She pinpoints how semi-structured interviews feature a loose structure of open-ended questions so that a specific area can be explored and so an interviewer or interviewee can pursue an idea or response in more detail (p.12).

> *Qualitative interviewers try to be interactive and sensitive to the language and concepts used by the interviewee, and they try to keep the agenda flexible. They aim to go below the surface of the topic being discussed, explore what people say in as much detail as possible, and uncover new areas or ideas that were not anticipated at the outset of the research. It is vital that the interviewers check that they have understood respondent's meanings instead of relying on their own assumption* (ibid, p.14-15).

It was important to bear in mind that the skills required for interviewing were perhaps different to skills I already possessed as a clinician, with others potentially being more transferable. Versatile skills included working flexibly, acute observational skills, noticing the verbal cues as well as the non-verbal (body language, facial expression, skin tone, perspiration, pupil dilation, for example), possessing an ability to continue thinking and working in periods of silence, plus noticing when this may need to be broken with a prompt or clarification for further thoughts. Britten (2000), building upon Whyte's (1982) six-point directiveness scale, emphasises the significance of an interviewer noticing how directive he or she is being, whether cues are picked up on, leading questions are asked and whether there is enough time given to clarify answers. The directiveness scale for analysing interviewing technique numbered below, is not to enforce that *"non-directiveness is always best"*, rather the amount of directiveness should be appropriate to the style of research. For example, to maintain control with those participants that may be more verbose than others (p.16).

1. *Making encouraging noises*
2. *Reflecting on remarks made by the informant*
3. *Probing on the last remark by the informant*
4. *Probing an idea preceding the last remark by the informant*
5. *Probing an idea expressed earlier in the interview*
6. *Introducing a new topic*

*(1 = least directive, 6 = most directive)* (p.17).

The questions constructed for the interviews were designed with the participants in mind as well as the aim of the study and what I hoped to explore. When forming these and prior to conducting the interviews themselves, it was helpful to have in mind Coar and Sim's (2016) study into the methodological implications of interviewing professional peers. This exemplified how many participants involved in interviews with a professional colleague regarded the process as a test of their professional knowledge, but that it also served as an educational process. Some considered the interviewer as an authoritative source of clinical information and hinted at feelings of professional vulnerability in relation to possible scrutiny of their practice or knowledge (p.251). Further pros and cons were also formed in their conclusion,

> *As an insider, the interviewer can gain potentially rich insights by capitalizing on a shared culture and common stock of technical knowledge, as well as feelings of collegial trust. Conversely, a need to project a positive professional identity to a colleague may mould the informant's responses, especially when the objectives of the study bear upon professionally sensitive or contentious issues* (p.255).

Sykes and Hoinville (1985) mention two contradictory hypotheses regarding the physical presence of an interviewer during an interview and how this might affect the reporting of delicate subject matters. With the interviewer not present, the interviewee may feel less threatened by questions which may be of a more sensitive subject. On the other hand, they argue that the presence of the interviewer can encourage participants of a study to feel more relaxed and therefore more forthcoming (p.98).

Graham (1983) suggests that interviewing in depth provides more valid information than a survey, for instance, as it allows the internal experiences of the participant to be expressed with more fluidity as well as non-verbally. Contact between researcher and participant, as in any human interface, will incite a variety of feelings. This may provoke unexpected behaviours and responses which can be informative of the research relationship and understood by employing the psychoanalytic term Countertransference. Laslett and Rapoport (1975) document the importance of taking the psychodynamics of the interview situation into consideration, specifically being aware as an interviewer of feelings during the interview and how these impact upon the process. They make use of two key components of psychoanalytic theory, transference and countertransference.

> *In its original psychoanalytic context transference refers to feelings derived from earlier experiences which are projected on to the analyst. Countertransference refers to similar feelings on the part of the clinician. With respect to interviewing…the interviewee develops an identification with the interviewer or vice versa. As a result, respondents may produce what it is assumed the interviewer wants to hear, or interviewers may accord particular features of the respondent's experience undue prominence* (p.105).

Heimann (1950, p.81) asserted that countertransference is an, *"instrument of research into the patient's unconscious"*. The metaphor of vibrations, much like from a resonating tuning fork or telephone receiver, from the patient's unconscious provides knowledge about their inner world which the analyst's 'picks up'. Holmes (2014) likened this process to that which occurs between the researcher and participant, and thus, considered countertransference to be a research tool (p.168). Similarly, Parker (2010) suggested that countertransference could be used by psychosocial researchers to define, *"feelings that cue the researcher into what they think is occurring between them and their objects of study"* (p.18). Holmes illustrates three ways countertransference is often used within psychoanalytic literature: (1) Interfering Countertransference which refers to the muddying elements of the analysts' own idiosyncrasies which can hinder the therapeutic process (taken from Freud's understanding of the concept). (2) Useful Countertransference, a post-Freudian concept where elements of the patient's neurosis become unconsciously transferred onto the analyst and become a useful tool in understanding the patient's inner world. (3) Intersubjective and Co-created countertransference which contains both aspects above but cannot be defined exclusively as the patient's or the analysts' but as a corollary of their interaction. These dynamics and the theoretical underpinning also felt pertinent to the support groups and what may be enacted and/or enlivened as conversations and thoughts materialised and developed.

When considering what I experienced compared to the theory highlighted above, I felt that Graham's (1983) ideas were still relevant, and that in-depth interviewing enabled me to be more in touch with personal reflections of the interviewees and the thoughts they had on their relationships and work with unaccompanied minors. Britten's (2000) 6-point directive scale felt pertinent depending on the question asked and how comfortable or not it felt for the participant to converse about and explore. This was indicative of how directive I then was in my response. One particular question about the statistics of unaccompanied minors entering the UK compared to the dispersal into the local area, provoked a reaction in many interviewees

where I became the 'professional in the room' who possessed all the knowledge and which noticeably altered the dynamics between us (Coar and Sim, 2016). When considering the countertransference relationship with interviewees, there was a noticeable fine line and interplay between how open or restrictive they were about sharing certain feelings and accounts. Some answers felt tailored to what they felt I wanted or expected to hear, whilst other accounts revealed more about themselves, their core beliefs, and values. When these felt too overwhelming or visceral, they were projected onto other groups (such as being the foster carers' thoughts, or a social care problem).

## Data Analysis

Thematic Analysis is a widely used tool which offers an accessible and theoretically flexible approach to analysing qualitative data. When utilised, complex human experiences can be explored with the capacity for the researcher's own theoretical point of view remaining as an important part of the work. Thematic analysis can be conducted within various ontological frameworks and felt the most appropriate for the analysis of both sources of data.

Terry et al (2017) highlight how thematic analysis requires a 'bottom up' approach where what is in the data is used as the starting point and foundation for identifying meaning and interpreting data from which code and theme development can grow. However, they also highlight how there can be, *"fallacy in this idea, as the researcher is never a blank slate, and inevitably brings their own social position and theoretical lens to the analysis"* (p.22). Codes can be understood either as Semantic or Latent. The first captures the explicit meaning of the data identified at the surface level. Latent coding encapsulates implicit meaning which requires a deeper layer of analysis and encapsulates ideas, concept meaning, and assumptions which are not overtly stated (Terry et al. p.22).

Braun and Clarke (2006) propose that, *"...[a] theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set"* (p.82). Willig (2013) refers to a theme as a, *"...particular recognizable configuration of meanings which co-occur in a way that is meaningful and systematic rather than random and arbitrary"* (p.58). Relationships and associations between codes and themes can be characterised via thematic maps which look similar to mind-maps or spider diagrams.

Willig goes on to propose the difference between a code and theme. Coding data requires a thorough working through of a text, identifying 'meaning units' or labels which capture the

meaning identified. These are basic units of meaning captured in a descriptive manner where multiple codes can be given to the same section of text. Themes capture clusters of codes and institutes a higher level of analysis when compared to coding (p.62). Braun and Clarke (2006) further clarify that themes exist in our heads from the justifications we apply to data and the links we create to understand them.

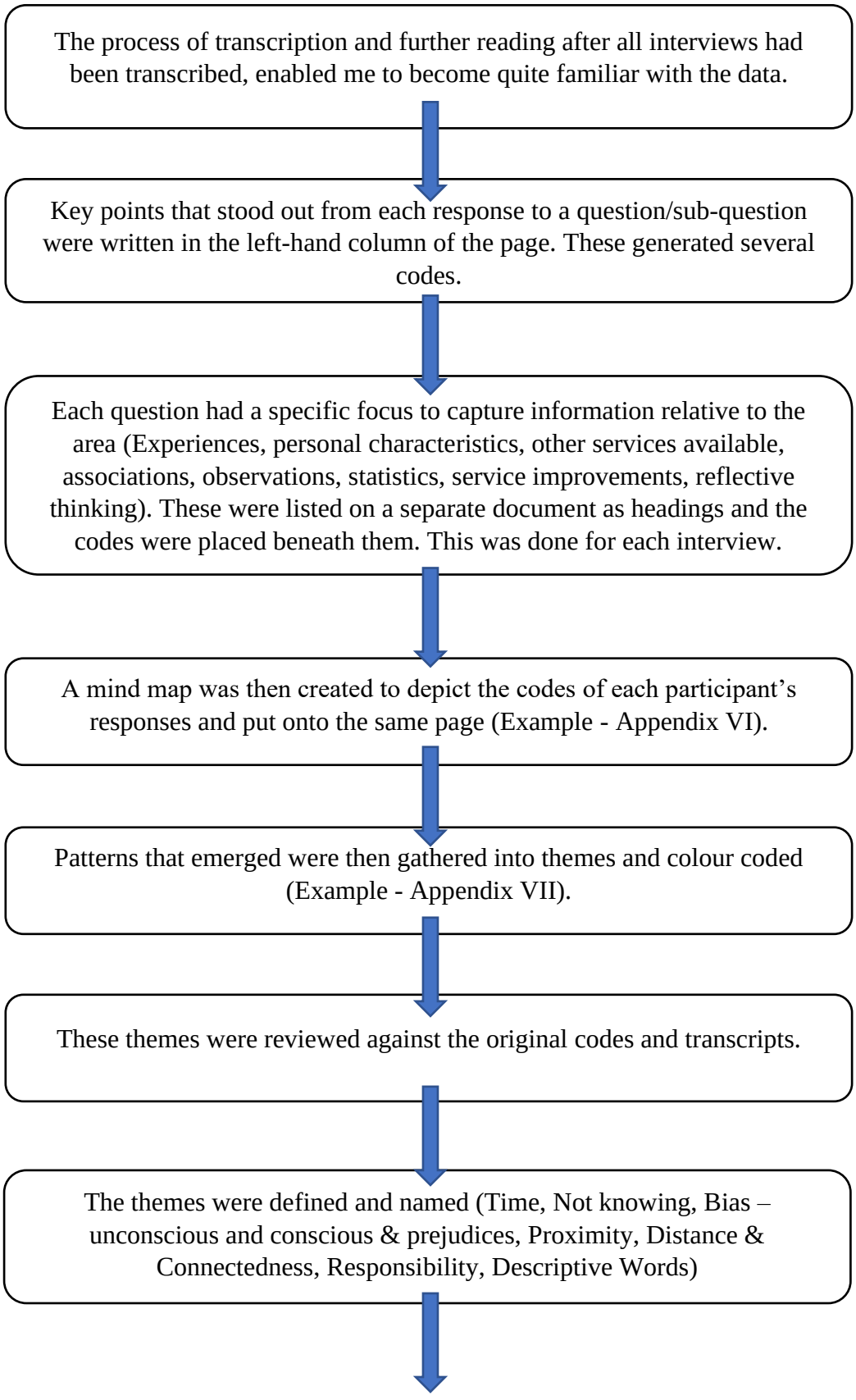
There are six phases of thematic analysis (Braun and Clarke, 2006; Willig, 2013; Terry et al, 2017):

1. Familiarising oneself with the data, which can be done through the process of collecting the data itself, during transcription for example.
2. Generating codes, where the researcher tends to immerse themselves deeper into the data which then creates the building blocks of analysis. It is here that similarities and patterns materialise across the data.
3. Themes are developed by the researcher which are like that of a draft piece of writing, not definitive and flexible to change. It is important to ensure at the start of this stage that support on coding the entire dataset has occurred before transitioning to constructing themes.
4. Review potential themes
5. Define and name themes
6. Create the final report which is the last prospect to make changes which strengthen the analysis and clearly communicate the analysis 'story of the data'.

Thematic analysis is frequently described as an easy-to-use qualitative method, but this reputation together with its lack of a definitive theoretical foundation can lead researchers to make the mistake of conducting thematic analysis deprived of a theoretical and epistemological standpoint. Themes are then created which do not represent anything specifically. Furthermore, a researcher can become so convinced by "*a priori codes identified on the basis of existing literature and theory"* they become restricted and limited in their awareness of new concepts emergent from the data (Willig, 2013, p.6).

Although the process of analysis was conducted using the same method, analysing the data generated from the interviews was quite different from the that of the support groups in various ways. Both are separated into two sections where the process is illustrated in flow chart form to summarise this.

**Interviews:**


The process of transcription and further reading after all interviews had been transcribed, enabled me to become quite familiar with the data.
Key points that stood out from each response to a question/sub-question were written in the left-hand column of the page. These generated several codes.
Each question had a specific focus to capture information relative to the area (Experiences, personal characteristics, other services available, associations, observations, statistics, service improvements, reflective thinking). These were listed on a separate document as headings and the codes were placed beneath them. This was done for each interview.
A mind map was then created to depict the codes of each participant's responses and put onto the same page (Example - Appendix VI).
Patterns that emerged were then gathered into themes and colour coded (Example - Appendix VII).
These themes were reviewed against the original codes and transcripts.
The themes were defined and named (Time, Not knowing, Bias – unconscious and conscious & prejudices, Proximity, Distance & Connectedness, Responsibility, Descriptive Words)

These themes were reviewed a few times and then finalised within the writing of the Findings chapter, so the story of the data was clearly told (Time, Working with the unknown, Difference and Diversity, Distance and Connectedness, Whose responsibility?).

**Support groups:**

The process of transcription took several months as the content of the material evoked emotional responses I had had within the group itself, as well as new feelings and thoughts whilst listening and typing. I found myself requiring space to digest the material I was hearing and reading, often several times. It felt like I was also digesting some of the content on behalf of the group which they were unable to process at the time. This resulted in a familiar acquaintance with the data.

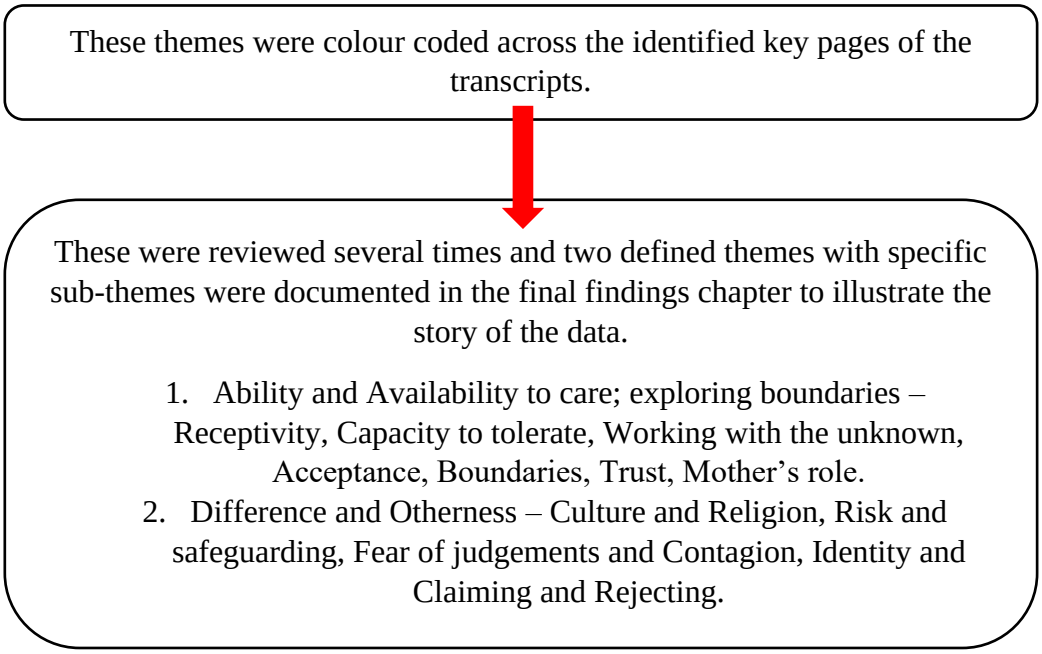
Codes were written in the left-hand column documenting key terms and subjects that stood out page by page.

For each focus group session, a separate document contained a list of the codes summarised on a page-by-page basis.

A mind map was then created, and themes were highlighted from patterns that emerged within each session.

Key pages that identified these themes were located from each transcript and familiarised with once again.

Themes were defined and named (Ability and availability to care, Trauma and Grief, Identity, Communication and language, Countertransference and Observations). These had multiple sub-themes which encapsulated the finer details evident within the transcripts.




I was frequently overwhelmed by the immense quantity of data during analysis and the content, often needing to take a step back and a break from analysis. I found that I became swept up within the material and often experienced feelings of stress and confusion by many themes and topics which were laced with trauma and felt particularly unpleasant. These emotive matters sometimes encouraged a biased lens and upon noticing this I would consciously keep some distance between myself and the data. It was also intriguing that the aim of this study was to explore the challenges within this care network and how, for me there was a challenge evident in connecting with the data itself. With both sets of participants and the data generated, it became more about identifying how the needs of the young people and those within their networks could be thought about, sat with and met, and that this became the overarching challenge of the network in providing support.

Although there were several sub-themes that were evident across both sets of data, one that specifically stood out was language and its use. There were particular words frequently used by participants from both groups when discussing unaccompanied minors and topics relating to them, which was prominent during analysis and at times appeared to indicate the unconscious thoughts and processes occurring for the participants. This is further explored in the Discussion and Conclusions chapter. I feel it also important to mention that within both processes of analysis, but maybe more so with the support group data, there was a very painful and difficult course of mourning the data I had to let go of due to the restrictions of time and length of this thesis. However, I worked through this by reminding myself there was a wealth of material to use in further studies perhaps in the future.

## Reflexivity and Validity

From the beginning of this process, I have maintained a reflective capacity, tracking my thoughts, experiences and potential personal bias within a research journal. Monitoring my research journey over the past few years this way has enabled me to have insight into the research process, as well as my internal processes. It has also been important to maintain an open dialogue and have discussions with colleagues in the field and supervisors, so as not to become lost, overwhelmed, or blind sighted by the research experience, the data or my own predispositions.

I found it helpful from the beginning of the research process to consider some of the dimensions that might arise prior to data collection and how I would approach these. These were,

- Leading questions within the interviews required thoughtful consideration as to what I wanted to find out about and why, thinking about any biases I may have or any that were evident within the service.

- Audio recorded sessions and their anonymization. How could this affect the responses of the participants especially as this was made conscious to them before the questions were asked and the discussions took place.

- Similarly, audio recordings and transcriptions of the groups could impact upon the participants' responses. They may become more defensive about what they would say.

- Would I introduce bias because of how professionals were selected to be a part of the study? This may be conscious and unconscious on my part related to who I selected, how I perceived their views on this topic relating to historic conversations and interactions, and the influence of their own ethnic and cultural backgrounds. What influence might their own professional training and backgrounds have?

- The population I had access to for this research study were predominantly white British and middle aged. I needed to keep in mind how this may only give an insight into the thoughts and opinions of this group of individuals and the limitations of this. Also, my own ethnic background which is white British and its effect upon the research and work undertaken would need to be reflected upon.

- The setting where the interviews and groups would be conducted could hold connotations for the participants involved, so it was important to consider how this may influence their responses and ability to be at complete ease with the process.

A few of these anticipated issues did arise, for example the audio recordings and how this impacted upon participant responses, the participants ethnicity, and the various settings used. Trust appeared to play a part in relation to the recordings in both the interviews and the groups, but in different ways. For the professionals there were subtle remarks about making sure they were getting their points across correctly and some anxiety about using the 'correct words'. However, our pre-existing working relationship meant that there was a certain level of trust and a preconceived idea of a mutual understanding which meant the recordings felt alright. For the foster carers the fact the sessions were recorded was mentioned several times explicitly with an air of caution, concern, and mistrust. It felt important and helpful to name this lack of trust in me and perhaps the purpose of the research and reflect on it aloud with the group. It was also noteworthy that the only 'foreigner in the room' amongst the white British cohort, including myself, was the Co-Facilitator. Thus, some questions about religion and difference were markedly directed towards her perhaps for further clarification or for a different perspective. I was also mindful that the group had a shared identity in their ethnicity which may have united them and encouraged a faster cohesion as they met each time. Lastly, the professionals seemed to be most at ease in their setting as interviews were held in workplaces. For the foster carers, the building utilised was familiar but not the rooms. The move between one room to another part way through the group sessions was unsettling and did have an impact upon some of the material shared and discussed. Again, providing preparation and naming the anxiety provoked, encouraged a conscious awareness that the group could then think about.

Clarity of the research design, boundaries of consent and confidentiality, security of the setting and confidence in the investigator by both the support group and the interviewees, were all vital to ensure participants felt able to give honest accounts of their experiences, their feelings, and the thoughts they shared. As Mawson (2019, p.82) highlights,

> *"Before such difficult feelings can be openly explored…it is necessary to provide conditions of safety, respect and tolerance, so that anxiety and insecurity can be contained and examined productively. It is essential that a bounded space is created*

*within which participants can begin to tolerate bringing more of their feelings than they are used to doing in other work activities, in an atmosphere which encourages openness and self-examination".*

It is also important to acknowledge that the data analysis represents interpretations of my records as I understood and felt them to be. As chief investigator, my role was to interpret the information gathered, decipher what I felt was important within it and describe what I thought was happening. As Charmaz (2006) highlights, the researcher's role in this way is central as *"we chose the words that constitute our codes"* (p.47).

Lee (1993) highlights that there are *"many ways in which interviewers can affect the validity of the responses they receive"* (p.99). In relation to sensitive topics, he emphasizes the effects of two kinds, the first regarding how social characteristics of the interviewer themselves may have a biasing effect upon the results. Secondly, the expectations the interviewer has of the interviews themselves. Holmes (2014, p.173) argues that emotions will be especially strong and become activated in researching sensitive topics,

*…if embraced and addressed, the researcher's emotional reactions can be an important source of reflexivity and data' (Gemignani, 2011: 701), that is, the emotional state of the researcher is tied up with the communication of the participant.*

It has been debated whether a researcher's analysis of feelings and behavioural reactions in research, commonly known as 'countertransference analysis', can generate valuable data. Holmes (2014, p.179) emphasis that these reactions should not be studied in isolation but rather in collaboration with evidence cross-compared with data from another research setting and modality. Stromme et al. (2010) views of reflexivity in the research setting are helpful here and highlight the need for, *"extensive …reflections in the research interview in order to be able to understand more of the quality of the interaction"* (p.221). Holmes further highlights how a qualitative researcher is in an advantageous position compared to a psychoanalyst,

*There are ways in which research data can be cross-compared, some of which could be unethical in the analytic situation. For example, the qualitative researcher may be more free to make use of a tape recorder for interviews, and provide a more flexible frame of interaction (e.g. not having to keep to the 'analytic hour', or having the freedom to ask for a relative's or teacher's views) (p.172).*

Data extracts were employed to accentuate the findings from analysis and were taken directly from transcripts with no amendments to what was said by participants. However, it was important to be conscious of the fact they were lifted from fuller conversations, thus what and how things were said added to the themes highlighted and what was evoked during analysis. As they stand alone in the findings chapter, they may appear to the reader to offer another set of thoughts and direction, but this would need approaching with caution so as not to take them out of context. The main intention of their inclusion was to evidence my interpretations, support the validity of the data and allow the reader to have a more in-depth perspective of what took place with the groups, thus bringing them to life.

## Limitations of the study

One of the most striking limitations of this study was that there were no male foster carers involved. Caring for young people was the main occupation for the females recruited in this study, with the males having other employment outside of the family homes. This meant they were unable to attend the support group at the time I had arranged. Maybe evenings would have been more amenable for them, although this was not practical for me. As a result of this there is no couple perspective, only what was brought alive in the group by the women, as well as their own internal couples. There could be a valid argument that a male perspective on the topics shared and discussed is lacking which may have brought further emphasis to the themes present and analysed, or presented new and different ones entirely.

Attendance at the support group was variable, with only one out of the six sessions having 100% attendance; four of the sessions were attended by five foster carers and session four was only attended by three. Reasons for these absences were varied; some had a previously planned holiday during the period of research, others had last minute appointments they had to take their young people to, one foster carer unexpectedly accommodated a new young person who was on a safety plan which prohibited her attendance, and one foster carer needed to attend a funeral. Those that were present more consistently appeared to be those that were more vocal with their thoughts, compared to those that took a quieter role in the group and an alternative perspective. This may have discouraged certain participants from attending as much as they might have been able to and thus impacted upon group discussions, and the data generated.

The voices of the unaccompanied minors referred to in these groups are also missing from this study, although, they were brought to life in the minds of the foster carers and to the room by re-enactments of their behaviours and specific interactions. However, these are from the

perspective and interpretations of the foster carers which were inevitably tainted by their own bias and emotional states at the time, so not a true representation.

I also feel that there is a considerable amount of data that has not been made use of in this study which would benefit from further analysis by more than just a sole researcher. The data I acquired was so rich and powerful there were limits to what I could engage with and analyse. It was a task which was incredibly intense at times, perhaps indicating the overall sense of the topic area itself. The use of another researcher's mind, or several of them, may have aided in the task of analysis and produced a deeper level of thought and discovery from the data. However, the data commented on within the findings was significant enough to merit inclusion in this study, but it is exciting to consider what else the data may hold which has not yet had the attention it deserves. Coar and Sim (2006) consider how both a clinician and a non-clinician in the interpretation of the data gained from interviews with professionals, for example, may offer a unique perspective, something which a future study of either this data or this subject area might benefit from.

The next chapter lays out the findings from this study, with examples from the data gathered to accentuate the themes present across both sets of participants.

## Findings and Discussion

Due to the two sources of data collection (support groups and interviews), this section will be divided to allow exploration of both separately, before discussing similarities and disparities across both. Within these two parts prominent and related themes have been grouped together to form sub-headings. Due to the large amount of data and information gathered, this served as an effective way to ensure the task of analysis and writing up was manageable and less overwhelming. The journey, both in the context of the young people and the research process, will be an underlying theme explored and held in mind throughout, as will professionals' views on the similarities and differences between Looked After and Unaccompanied children and young people. It is also important to note that the titles 'Interviewees' and 'Professionals' will be used to define the participants that took part in the interviews. 'Group members' and 'Foster carers' will be employed for those who took part in the support group sessions.

### Part 1 - Foster carer support groups

This first part is divided into two key sections which were most salient across the transcripts. The Ability and Availability to Care, and Difference and Otherness. Through conducting this research and during analysis, it became apparent that trauma has no edges, or boundaries. It cannot be split nor defined into its own unique chapter, rather it runs throughout both key sections. Trauma had an impact on those close to the young people who had suffered trauma and contributed another layer of complexity to caring for and relating to unaccompanied minors for the foster carers.

Each theme will have extracts and examples from the six foster carer sessions, to illustrate the groups' movement of thought and shifting states of mind. The examples will not only be utilised to organise and make sense of the foster carer's thoughts and feelings, but to demonstrate how I understood their minds and how they understood each other's. By telling the stories of how they saw and experienced their interactions with the young people they fostered, the challenges they faced when attempting to provide therapeutic attention to the unaccompanied minors they had in their care will be brought to life.

Two of the main tools utilised working as a psychotherapist, are observation of conscious and unconscious behaviours and countertransference reactions when working with others. Being in the position of constructing and thus leading the support group cast me into a novel position. It was of interest to note during and after the group sessions what feelings were stirred in me and what thoughts I was often left holding onto long after the group had concluded each

fortnight, and those that I evaded completely. Within each section I will present my observations of the material, group dynamics and my countertransference. This will trace the journey of how I was utilised by the group, what it felt like from a researcher's position to be a part of such a group and any parallels or conflicts between my experiences and the foster carers.

## The ability and availability to care; exploring boundaries

This theme consists of multiple subthemes foster carers discussed and communicated over the six group sessions. Topics mentioned that fit under this over-arching heading were receptivity and having capacity to tolerate, the struggle with rejection and abandonment, working with the unknown, acceptance, boundaries, building trust and a mother's role. Specific attention will be paid to how these impacted undesirably and encouragingly, on a foster carer's ability and availability to care for and nurture unaccompanied minors they had in placement. The ability and availability of my mind and shifting role within the group as a whole and to its individual members will also be considered.

### Building Trust and a Mother's Role

Whilst all the sessions were busy and full of valuable information, the first one contained a frenzy of chatter, laughter and communication which was projected into the room along with reactive feelings and emotions. During transcription, making sense of the conversations was problematic as one person talked over another and multiple people talked at once. There were no silences and minimal pauses to allow for thought or for individuals to sit with anything uncomfortable. During some of the conversations I had waves of sickness which ran through my stomach and after the session I felt disconcerted which manifested in a headache. Without prior agreement, both the Co-facilitator and I wrote notes even though there was a recording of the session verbatim. For us this seemed to serve as a thinking function, enabling us to keep track of the flow of conversation whilst our thinking capacity felt invaded and flooded. Maybe for the foster carers this notation served as some comfort. Writing down certain comments and thoughts may have implied we were actively listening and taking their comments seriously. My headache was potentially a reaction to the complex and dense material I was left holding for the group, with little to no room to digest it.

Their conversations in this session mainly focused on the difficulty of caring for unaccompanied minors. There appeared to be many blocks that made it difficult to connect with these young people and trust what, as foster carers, they were presented with. The position

of being a ‘mother’ and how this role could be performed was considered. The covert question seemed to be, could they tolerate the uncertainty and discomfort of this position, and would the young people really want or accept them if they delivered care within this role.

*FC5: …but all of me (inaudible) wants to believe them.*

*FC2: yes*

*FC5: And wants to do my mothering role, and that’s why*

*FC2: (talks while FC5 speaks) yes, coz that’s’ why we are doing this job*

*FC5: Yeah! And then sometimes you think, oh my god I’m like gutted for something, you know, coz you’ve found out perhaps that isn’t so true, or this has happened, or the stories have changed like you’ve said it’s, it’s quite gutting*

*(Some sympathetic and agreeing tones as FC5 speaks)*

*FC2: Coz we actually want to care for vulnerable people,*

*FC5: Exactly, you want to ‘aww bless’ you know. To make it all good and I’ll speak to the social worker yes, you know I’m on their corner (inaudible), all the way just like my own children. But there’s sometime oooffff.*

There appeared to be a spilt between seeing themselves as ‘mothers’ and doing a ‘job’. Trust had a large part to play in how receptive they could be in their availability to take on these specific roles. There was a desire to hear and believe the often-traumatic stories they were told and have an empathic, maternal response. But, the apprehension and realisation of deceit was incredibly painful, and for some this appeared to unsettle them internally. The expression of feeling ‘gutted’ when these were discovered to be untrue indicated how profoundly affected they were, feeling as if their inside connections had been ripped out, exposing their vulnerabilities and leaving them feeling insecure and hurt. The conundrum then being how can you claim someone and advocate for them when you cannot trust them with certainty? Consequently, it became more appealing to see the role of caring as a ‘job’ which had conceivably less emotional connections and responsibilities:

*FC4: I guess in the end the only way you cope with it is you see it as a job rather than,*

*FC1: and that’s how it is*

*FC4: it becomes a profession rather than,*

*FC2: I can't do it like that*

*FC4: actually wanting to do it for the reasons you went into it.*

*FC1: yeah that's what, how it is with ours and this is what I've thought and it's not what I want*

*FC2: I don't want to be like that*

*FC4: and then you hope it doesn't damage you as a carer should you ever get that one that comes in the door that actually can then build that relationship with that*

*FC1: yeah*

*FC4: you don't become too sort of cold yourself*

This professional identity appeared to serve as a protective boundary, preventing humiliation and denigration of the carers, but this stimulated a worry of 'at what cost?'. Damage and vigilance about the reprisals of making a connection or not with a young person were considered in three main ways by the group:

1. Sharing an experience: The harm caused by what might be absorbed and internalised by the carers from a young person's experience shared or which becomes enlivened within their relationship.
2. Becoming emotionally disconnected: Needing to protect themselves from being taken advantage of emotionally or being overloaded with something unsavoury.
3. Becoming a 'Cold Carer': Switching off all emotions and disassociating from those around them in the present and future, with a worry of not connecting with those who may need authentic and personable connectivity.

The difficulty of ending these sessions was present from the very beginning of the group's formation. There was a discussion about the time we had to cover the various topics the foster carers had identified in our initial meeting and a sense that this would be limited. As the end of our first session was called it felt rushed and that there was a lot more that needed to be said. The group was unprepared for the severance, felt uncontained and as if they were being thrown back into a harsh reality. Even though notice was given of the time we had left, it seemed not even this could be taken in by the foster carers. As an unconscious reaction to this, I later realised that I had paused the recording devise then switched off the handset, rather than saving it first. The data on this device was lost. I was incredibly annoyed at myself for losing valuable

information the foster carers had shared. It was almost as if I had silenced their voices after they had explicitly communicated how much they wanted to be heard. There was a powerful feeling left within me of abandoning the group and being overwhelmed at times, this perhaps manifesting in my lack of capacity to hold and think logically about the saving process. Consequently, I had become completely disconnected. Luckily, I had a back-up recording device, but the quality of recording was poor. Extracting files from it to save externally to later revisit was obstructive, tiresome and took a lot of time and patience. It was a mistake I was more consciously aware of for the following sessions.

Group discussions also focused on contempt and greed. Unaccompanied minors were reported to want all the benefits of living in care without restrictions. There was envy towards the young people, with it feeling like their needs were met by external services whilst the foster carers often felt left with extraordinarily little or no external support. Conceivably the carers themselves, unconsciously, wanted to be able to care without having any emotive consequences or restrictions.

> *FC2: It's never enough though,*
>
> *FC5: No (disheartened tone)*
>
> *FC5: Every, every child I've had it's, it's never enough…They want more money…..They're never satisfied.*
>
> *FC2: Because, do you know what I feel happens, I think they give up soooo much to come here believing it's going to be a better life, they under estimate what they are giving up, so their country, their culture, their food, their family, the weather,*
>
> *CF: Freedom*
>
> *FC2: Yeah, yeah*

The use of the word 'freedom' highlighted not only what the young people themselves may have 'given up', but the restrictive nature felt in the role of caring (this will be further explored later in this chapter). Thus, this stirred unconscious contempt within them with a parallel struggle for both the young person and the carers of who was giving up what for whom, and for what gain? This was further aggravated by the need to protect themselves from rejection as they questioned what the young people were really getting from them, whether it was valued and if they could bear to make connections when there was the threat of betrayal.

It seemed for the carers, tending to the unaccompanied minors was much like caring for an unregulated and anxious infant. They were met with constant demands which felt confusing, unmanageable, and emotionally draining. Rather like having to look after a new infant, there was a feeling of being unprepared and de-skilled. This was especially so as the young person coming into their care was new to them and their families, with no prior knowledge of how they may relate or respond. This made me think about 'learned helplessness', described by Cox (1986),

> *The mother believes, for example, that in whatever way she looks after her baby, she will fail in this task and adverse consequences will result from this failure. She is then, …in a state of 'learned helplessness' or depression* (p.34).

The theme of 'motherly qualities' ran through each session, with idealisations of what it took to be a 'good enough' mother. Deutsch (1947) and Cox (1986) both draw attention to the process of identification that often occurs in child rearing between the mother and her baby, as well as her own mother. An awareness of this cross-generational link can be illuminating when trying to ascertain a mother's presenting problems. For example, a woman with a hostile relationship towards her own mother may find that this identification makes it harder to be a 'good enough' mother herself. Consequently, this may be projected onto the baby who is considered undesirable or rejected. This was an additional layer to an already very complex and multifaceted relationship between a foster carer and unaccompanied minor.

Trauma and its impact upon the young people and how they present was also considered as voracious and disdainful. Foster carers described being directly faced by trauma which at times felt uncontrollable and all-consuming, with little external support to understand or contain it.

> *FC2: …but the trouble is that people are just people. Yeah people are human and teenagers have particular ways of behaving and sometimes their behaviour is just bad. Or unacceptable or however you want to call it and yet anything is explained by 'oh you need to give them more support then because they're traumatised' and they are being really unacceptable, but 'just give them more because they've been traumatised'. So, it just feeds this, this monster really of wanting more, that's been my experience.*
>
> *(Some affirming tones from the group)*
>
> *FC2: And I think yeah of course they have been traumatised; we know that we've seen them when they come in the door. You know we're the ones that do the, the work…*

*FC1: All our children are traumatised,*

*FC2: Yeah, yeah*

Trauma was pervasive and intrusive in the foster homes and felt to be uninvited. It was perceived as an expected part of the 'work' and of caring which over time had become familiar to the foster carers. The 'monstrous' nature described communicated the frightening and inescapable attributes of trauma they faced and further emphasised the need for foster carers to have caution and defences in place. However, verbalising and sharing such views and attitudes inevitably triggered feelings of guilt in the foster carers. Many left the first session separately or in pairs, but on this occasion FC4 stayed behind. She told me she felt 'positives' were missing from the session and wanted to ensure that my needs were being met by the group. Consequently, in my countertransference I had feelings of uncertainty as I questioned whether I was meeting the group's needs and expectations. Akin to the foster carers, I was concerned about what harm I might incite through inviting the 'trauma monster' into the room by encouraging such conversations, subjects, and thoughts.

An increase in brief pauses during the second session provided space for those who did not talk as much to introduce their thoughts. Interestingly it was FC3, who was absent from session 1, that utilised these brief moments to share her successes in fostering and examples of relating with her accommodated young person who had been living with her for three years.

*FC3: Yeah, because he doesn't want anything to do with his family because of the abuse he suffered, he sees and I see him as my son.*

*FC2: Ahh, tut (affectionate tone)*

This introduced a narrative of love, affection, and ownership into the room which the remainder of the group paused and attempted to empathise with. FC3 continued to explain a recent Home Office decision which meant the young person's future with the family could be ruptured. I felt saddened at the time as I sat and listened to the foster carer's reactions which harmonised with those evoked in me. I felt helpless with no words or helpful comments to improve what felt like an awful and thoughtless decision made by an external service. Again, I began to question whether I was doing more harm than good in raising these thoughts and feelings. However, the group seemed to be more united through such conversations and upon calling the end they left the room as a cohesive group, united.

I was left considering how painful making such connections were and how alive this had become in the room, something I think alarmed and unsettled me which I was unprepared for. It seemed evident that external services and the decisions they make have a monumental impact upon a foster carers' ability to not only physically offer care and support these young people, but emotionally too. With so many decisions being out of the foster carer's control, and little to no consultation about verdicts, it was understandable that an automatic reaction, and most likely unconsciously, was to gain control over whatever they could. One of those was whether to develop a relationship with a young person or not.

During the third session the group appeared more open and in touch with how they were feeling. They began to consider what unaccompanied minors wanted from them, what roles they were cast into and for what purpose. Lots of information was shared and I found myself halfway through the session getting a little lost in the conversation. Reflectively, it seemed that I was beginning to connect and be in touch with the stories and accounts differently and becoming more of a group member. With this came a worry about my ability and capacity to hold not only the information being shared, but the emotions and feelings too as well as contain them. At the same time, I panicked about the recordings and whether I had pressed record on the devices or even turned them on. I was struck how this linked to the groups' concluding feelings at the end of the session; how could they hold onto these young people with certainty and conviction.

Foster carers felt that at times they were pushed into a detective role. This was consequential to dealing with large quantities of unknowns which was *"quite scary"* and anxiety provoking for them. This role was later termed 'foster mother detective' by the Co-facilitator. However, it seemed that love surpassed this unsettling ambivalence for some foster carers, and the group sessions provided an avenue to discuss and think about this.

> *FC3: well the father was here first the Home Office are saying and then the father went to the Albanian Embassy and said, 'I want to bring my wife and son over'.*
>
> *FC5: Ahh*
>
> *FC3: so, the Albanian Embassy write him a letter saying she could bring him out of the country, but he still maintains that he came in, I'm not sure how he came in*
>
> *(some noises of surprise from a few in the group)*

*FC3: but, what does it matter, you know, I love him, he loves us, the parents don't want him, even if he was with them, they've now abandoned him, they've made no contact with him, so whether they thought he'd have a better life or whether, I don't know.*

*FC2: maybe she put him, maybe they were together so far and maybe she put him on a lorry, separated them.*

*FC3: I don't know,*

*FC2: it's horrible not knowing though.*

*FC3: it is in a way, but I am gunna now, I want to adopt you, you are going to be my son but there's still not a lot of emotion there, it's not like, he didn't fling his arms around me and say oh thank you thank you I want to stay with you, he was just like I want to stay here*

*FC5: I know there's no emotion is there*

*FC3: no, there isn't any emotion when I think what we're giving up for him but*

*FC2: it's a big old decision though*

*FC3: I know he wants to stay with us, and maybe over the years we'll find out more, but I don't know if we ever will.*

There was an uncertainty of truth, but for FC3 this was not the priority, it was claiming a young person who she felt had been abandoned and this connectivity and affection trumped all other uncertainties. Others, such as FC2, appeared in a different position, continuing to search for answers to questions and seeming to feel abandoned and lost themselves amongst the unknowns which was *"horrible"*. The lack of emotion from the young people themselves was perplexing to the foster carers. It felt unappreciative and again this notion of what was being given up was mentioned, as if even this declaration of love and acceptance was not enough and their efforts at connecting were a thankless task. However, evidence of hope was present that one day things might become clearer, and not be stagnant with despair. This opened conversations about the need for a mother's intuition for some young people and how this required a connection which could not be forced but needed nurturing over time.

*FC4: yeah, I was supposed to be able to mind read because in his culture they don't talk about things, so*

*FC5: they keep it inside*

*FC4: so, when he's got an issue yeah, and it's hurting his heart then I should know…instinctively. Even though he shows no emotion about it.*

*CI: That's interesting though isn't it, it's almost kind of letting you know that he's missing a bit of a, a mother's intuition. You know you represent a mum,*

*FC4: yeah, yeah*

*CI: and you're not his mum*

*FC4: that's what we said, we said we know, we know our children since birth so we can read our children a lot better….but actually, you've only lived with us since January and so therefore we can't read, we can't read you as well*

This was an emotional conversation with curiosities as to whether the need to keep things in, not disclose or express feelings, was due to cultural or personal preference. It appeared safer to class it as a cultural response so that it felt less rejecting, although foster carers admitted it was hard not to take such things personally. There was evidence of a strong need for a maternal response and empathy, for feelings and desires to be noticed and taken in, and how for these young people it felt lacking and longed for. The raw description of 'pain in his heart' was powerful, possibly signifying that this young person had had an early life experience of their feelings and emotions being sensitively taken notice of and absorbed by a significant caregiver, this then being internalised. When considering similarities and differences between indigenous looked after children and unaccompanied minors, this example possibly sets them apart as many looked after children are unlikely to have had such early experiences.

Working with the Unknown and the Capacity to Tolerate

The fourth session was attended by only half the group, the lowest attendance so far, which sparked several anxieties; whether the group would persist until the sixth week, if they had had enough, and if the encouraged connectivity meant attending had become too difficult. With less participants one assumed there would be more space to talk and mull things over, but ironically in much of the session there was an incessant worry about time and not having enough of it. The 'not knowing' aspect of caring continued to inflame the foster carers' anxieties. However, naming this enabled some thought about what they might have opened themselves and their families to upon inviting unaccompanied minors into their homes as well

as what was left behind once a placement ended. The worry of making connections or not, what with, and the impact upon them as carers was also in their minds.

*FC4: when they leave, if you don't have that connection*

*FC1: yea*

*FC4: you don't feel, 'ahhhh, what a good job I've done'.*

*FC1: See I'm going through a real guilt at the minute (said loudly), because [young person] went,*

*FC4: yeah*

*FC1: and we had him for three years and he wasn't very close to anybody, he was very, I hate to say it but,*

*FC2: cold*

*FC1: they're very cold. Somebody said to me once, don't be too upset they're just quite tribal and they do whatever they can to survive, there's no, there's nothing more and that's just the way it is.*

*FC2: no, I don't think it's in their culture, to be emotionally connected with each other.*

Much like their concerns of becoming cold carers themselves, they were thoughtful of the young people's responses to being 'looked after' and their survival instincts. This provoked a feeling of guilt for some foster carers who felt unable to get through to them. At a deeper level, maybe there was also an anxiety that nothing had been internalised from their relationship and experience of living together. Much like the foster carers, the young people required defences to manage in the situations and environments they found themselves in. FC2 shared in several sessions a perplexing observation where her young person was living out of a locked suitcase.

*FC2: So, he's got drawers and a wardrobe, and then he went off and bought himself a sixty to seventy-pound large suitcase and all of his belongings are in there and locked.*

*FC4: Is it a trust thing?*

*FC2: Well it must be, surely?*

*FC6: control?*

*FC2: Yeah*

*CF: Is he ready to go?*

*FC2: Yeah well, I was really worried because the other one that left,*

*CI: So, he is already prepared*

*FC1: I know!*

The group tried to help FC2 understand what might be happening, questioning trust, the need to control and lastly safety. There was a fear of abandonment, it seemed from both sides of the relationship, and the basic function of needing to feel safe, it being from this that connections can grow. With a constant threat of moving, being abandoned, or let down how can a young person relax and feel safe enough to trust and 'unlock' themselves to facilitate and receive any form of connectedness, especially if history dictates a familiar and unsettling pattern? All this impacts upon the foster carers experiences of being able to relate or not. The task seemed impossible and overwhelming.

It was of interest to see how the group appeared to ripple from one state of mind to another each week and how this was largely impacted by who attended and what experiences and positions they brought. As trust developed within the group, in us as facilitators and of the space provided, it enabled the foster carers to revisit topics and feelings previously expressed, with more space to stop and reflect upon the hurt and disappointment they felt. As discussions progressed in Session 5 there was talk of the trauma present in the foster carers' homes and again, the lack of support they felt they had with this.

*FC2: I was the person she made full disclosures to, had to give evidence, had to give statements to the police, I've had to do lots and lots of recordings, I've had to go over and over it, and frankly it was absolutely-traumatic (last words elongated).*

The elongated final words powerfully accentuated the enlivened trauma present for this foster carer, internally as well as externally. It was apparent that the repetition in the group's narrative of accounts week upon week was having some impact upon its members, as well as the knowledge that these were being recorded each time by at least two devices. It is possible there was some anxiety still present regarding what would be done with the recordings, who would listen to them and how they might be judged. At the time there appeared to be no space in my mind to link this directly to the group, but reflectively I began to consider what it might be like to be a part of such a research group.

In my countertransference I had a strong feeling of frustration, as if things were not shifting and many topics were revisited. A discussion with the Co-facilitator after the group helped me to see how I had identified with the foster carers and had fallen into a role of wanting to 'fix' things. Rather than staying with the material they were bringing and work through this, it appeared I wanted to avoid this and move past it. Another example was a discussion about the pain FC1 expressed when she experienced visiting a detention centre alone. Unsupported by a social worker she had visited a young person she had recently accommodated who was in distress and suicidal. She described the *"horrendous experience"* and the shock of having no knowledge of where she was going. This was followed by a comment from FC2, *"there was nothing you could do".* I was struck by the parallel of FC1's position and the awful experiences and events an unaccompanied minor may suffer with a lack of control or forewarning.

It appeared that for me this conversation was too much as I was quick to remind the group of the 5 minutes remaining and shifted the topic to a question I had noted previously during the conversation. There was an implicit desire to move on and the restrictions of time and available resources limited my capacity to stay with and explore this discomfort further. Consequently, I felt guilty and as if I had abandoned FC1. The inability to cure and make things alright was far too painful to stay with. Again, I found myself frustrated and saddened which was also felt by the foster carers who considered themselves helpless.

As the carers continued to discuss, "*the standard that you need to be to care as a foster carer [being] a lot higher than it's been in the past"*, trauma being rife in their homes, and a diminished support network, they pondered how they were regarded by others and how this impacted upon their availability and ability to care. They felt *"unimportant", "patronised", "let down", "disrespected"* and *"at the bottom of the list".* They referred to their situation as *"weird"* as they were *"self-employed"* and wanting to be *"in charge"* and *"to say no"*. However, they felt uncertain of which *"group"* they fitted into as they were *"professionals"* and at times were encouraged and spoken to as associates, but other times were left out of 'professional' conversations and decisions and lacked control. This steered them to consider, in more depth than previously, how their caring role had impacted upon their family life and what they had sacrificed.

*FC3: you do give up a lot too (chatter and agreeing tones from the group)*

*FC1: you give up your life as a husband and wife*

*FC4: yeah*

*FC5: mmm*

*FC1: we can't link together it's got to be one or the other (mmm's from the group)*

*CI: what other things?*

*FC3: families don't understand anyway*

*FC5: no*

*FC2: children, our own children (low tone)*

*FC4: say you get invited to a barbeque*

*('Exactly' from someone in the group)*

*FC4: so usually that's you and your partner*

*FC2: yeah*

*FC4: and if you've got any birth children*

*FC2: mmhmm*

*FC4: and you're not, see you're like, ohhh (sigh), oh dear we can't we've got,*

*FC5: yeah*

*FC4: and you can't leave them at home can you*

*FC2: some people don't*

*FC4: you have to give up your social life*

*FC2: especially if your family sees some of the behaviour*

*FC5: mmm*

*FC2: towards you and your family they, they can't understand that, so they don't want to be inviting them around to their house*

It seemed the struggle with finding a place for these young people was both an internal and external effort. Foster carers tried to work out where they sat within their professional role and how this impacted upon their own family and network configurations. The additional conundrum was how they could accommodate a young person within their family and wider networks too, and with all this going on if there was any room or capacity internally in their

minds for them. With these new links and reconfigurations, it seemed preceding links were put under threat, such as the couple relationship. FC2 brought the word 'threatened' into the group when contemplating how people in society felt when seeing/being with these young people. She then informed the group, *"I'm quitting, I'm quitting"* followed by nervous laughter. With further exploration she and the others expressed the hopelessness they felt, and FC1 added that she felt her house was more like a hostel than a home. FC2 justified her move back to her previous vocation, stating that it was a *"combination of things",* but the expectations of fostering an unaccompanied minor felt *"unmanageable"* and that there was a *"need for more support".* It was apparent that FC2 had been asked more of than she felt she could give. Being a part of the support group may have aggravated her uncomfortable feelings and tested her tolerance further, consequently pushing her to such a decision. Then again, it had provided the opportunity to air her feelings and views which were validated and may have inevitably supported her in making this choice.

Receptivity, Acceptance, and the need for Boundaries

It was not a surprise that the final group session began with some trepidation. As a thank you, and maybe to sweeten the unpleasantness of the ending, I brought chocolates for the foster carers to share during the group. There were two absences, one foster carer who arrived late and one who discussed her thoughts about wanting to cancel. I spoke aloud about the difficulty of dealing with endings and there was an immediate response from the group about the contradictions they faced as foster carers when it came to a child moving on. They explained how some moves felt forced and were deemed not in the best interest of the child, other times they were quick with little notice, maybe long and drawn out, or were discussed and planned by social care but then mobilised without much communication.

The topic of endings was present in almost every discussion point of the group. FC2's decision to leave fostering was now well known and it was another ending the group had to mourn. I felt disconnected during some of the discussions as if I had already left and moved on. I found myself returning to thoughts of the first session, concerned about what I would be left holding, if I had capacity to carry it, especially with no planned opportunity to revisit it. Just as I had done in the first session, FC4 took notes during the final session perhaps feeling the pressure of containment of these pertinent issues now the group was going to be no more. It was also noteworthy that she collected up the remaining sweets at the end of the session, wanting to take them back to the young people at home. I speculated about what else she wanted to take away from the group experience which could be utilised at home.

Foster carers discussed how they felt torn and fed mixed messages from social care. They felt they had gotten into the job to take care of and nurture young people, but at the same time they were told the placements were *"only temporary"*. They continued to have powerful discussions about acceptance into their families which felt emotive and I was stuck with sadness in my chest.

*FC3: they want you to love these children*

*FC4: yeah*

*FC3: and what, just let them go (clicks her fingers) and forget about them. Well what sort of people does that make us?*

*FC1: I know of one social worker who said 'they've got their own families'.*

*(3 second pause)*

*FC4: but then I just see it as they just add to their family*

*FC1: yeah*

*FC4: they appear in your family and then it's a bigger family*

*FC1: yeah*

*FC3: family doesn't have to be blood does it?*

*FC1: Two of our boys are changing their Facebook name to our surname*

There was anger and frustration in the tone of the group which I had not heard linked with these feelings and comments before. There was an internal conflict and ambiguity which seemed to be driven by an external service which itself required defences and distance to manage. Ownership and belonging now superseded the endemic of anxiety previously felt in earlier sessions and there was an ambience of determination and opposition at being told how to feel and be. The group continued to discuss how the best carers were those who formed attachments and how they needed to strive for this level of connection and acceptance to fulfil their role as parents. They considered the disputes from social care that they must not be called 'mum and dad', how they were discouraged, and it was *"a bad thing for carers to form attachments".* However, they had also looked after young people who wanted to call them mum and dad, who wanted *"that association, connection with you"* and felt that was what *"what the child needs".* FC5 chuckled as she voiced her foster children, *"You Mumma Number two!"*

I was also shocked as FC1 talked about receiving training on 'letting go' and how she was given advice to *"move on coz there are other children out there".* She described an interaction with a social worker as she watched a traumatised boy leave her home via taxi to go to a children's home.

> *...the social worker that came with me put his arm around me and said, 'never mind, we've got another one lined up for you, you gotta move on now'!*

FC1 voiced that she felt her empathy was determined as a *"weakness"* and went on to discuss an ending of a placement with an unaccompanied minor that stood out to her. It concerned her so much she had emailed the social worker to express her thoughts. The reply she received was, *"you need to remember your boundaries".* Foster carers were subjected to role modelling from professionals which implied a need for strict boundaries and the requirement of distance to 'get the job done' when working with these young people. Thus, there seemed to be a complex relationship between professional's expectations and foster carers experiences where such boundaries became inconceivable, scepticism spiked and there was uncertainty of how they should relate. Communication that their relationships are *"only temporary"* may unconsciously restrict a foster carer's internal capacity to really make connections with and support these young people to grow, develop and feel innately understood. There was a stark reality of what these foster carers were faced with when caught between the pull to love and accept and the pressure to move on and take in more.

> *FC1: so that sudden ending, back to that sudden ending is really hard, I think*
>
> *CI: mmhmm*
>
> *FC1: it's like a loss, it's like a bereavement coz they just take them from you without, and you know the bond you have with children because they come and they got nothing and they're scared and they are so scared, and I do think it feels slightly different, they are very dependent on you, more than other children that have been through the system a bit you know. So to just pick them up, in a car with just two social workers, one he'd never met in his life, say we're moving you, then to go on a boat, when you've come on a boat that capsized, to put him on a boat and take him to the next place, when we've done everything to keep him off the boats,*
>
> *FC1: I think it's just a bit gun-ho.*

It seemed the endings experienced were abrupt and emotionally disconnected in some cases. Even though the groups' termination had been present from the very start, it felt it had come too soon which possibly left the foster carers feeling isolated and alone once more.

## Difference and Otherness

Like the previous section, this theme has multiple sub-themes which became prominent during the process of thematic analysis. Those that fit under this umbrella of Difference and Otherness are, culture and religion, risk and safeguarding, fear of judgements and contamination, identity, claiming and rejecting and achieving the right proximity. Once again trauma runs through these sub-themes and impacted upon how and if care could be provided or not.

### Risks, Safeguarding and the impact on being able to claim or reject

During the first group session there were moments of inaudible muttering in the background of louder conversations which could not be deciphered in the moment, nor later during transcription. These separate, smaller conversations provoked feelings in me of unease and I felt that my position of 'chief investigator' was tested as the hierarchy within the group became established. I also felt I interrupted others with my thoughts, and it was hard to verbalise comments and have them heard. It was of interest then when the foster carer's themselves began to discuss positions within their families, present and past, and the threat this appeared to pose,

> *FC1: We've found that's worst at home if they're the eldest son. So, if it's the eldest Muslim son,*
>
> *FC2: Oh, that's what I thought.*
>
> *FC1: then oh my god then it's, we've got one at the minute, it's a struggle,*
>
> *FC2: Yeah*
>
> *(Multiple members of the group all talk at once – inaudible)*
>
> *FC2: My young person thinks that if he, that if I'm using something that he wants I should immediately stop using it, despite the fact, I'm going to say it's my property (sentence ends high pitched and in slight disbelief).*

It was apparent that the intimidation I felt was also present for the foster carer's themselves, as they tried to work out positions and roles within their own families once accommodating and getting to know an unaccompanied young person. For FC2, firmly stating what was *her*

property indicated a sensation of being intruded upon, having something stripped away unexpectedly and the unpleasant and shocking nature of this, and hence the automatic reaction being to protect oneself from this threat. Later in the same session, FC2 talked of her struggles with being told, *"everything is no good, or in Sudan they're good".* This felt intimidating to her as she responded with, *"but this is England and in England this is, this is ok. "No, no, no good" he says".* Differences in their expectations seemed to emulate a battle for territory, with FC2 trying to maintain her ground in what felt to her as an invasion and war.

The three foster cares present in session three thought about how they came into fostering and how they had never anticipated accommodating unaccompanied minors, it was not something they had on their agendas nor what they had initially signed up for. FC1 talked openly about her 13 years of experience prior to taking in unaccompanied young people and how there had never been any requests to support them before.

> *FC1: We started with [young person] and I think we were frowned upon a little bit [by the community]*
>
> *FC4: You were! (affirming tone)*
>
> *FC1: We were. 'What are you doing bringing these people [into the community]?!'*

She continued to talk about the complaints from the local community and council for having immigrants living on her land in a caravan. FC2 expressed her thoughts that perhaps people felt threatened by them. However, FC6 brought another perspective into the discussion with her understanding of the togetherness and comradery these young people build as they travel thousands of miles to the UK. But then they experience the consequential and harsh rupture of their relationships upon entering the UK when they are placed in separate placements and stripped of their freedom to communicate as they wish (all mobile phones and numbers taken from them, for example). She voiced their loneliness and how *"not living their culture"* within the UK was *"like a big bomb shell for them".* The use of the words 'bomb shell' powerfully conveyed the raw and explosive nature of this abrupt separateness and a connotation of war and trauma which ultimately became enlivened in the foster care setting.

One of my most striking notes written during this session was *'Where is the love?'*. Discussions regarding terrorism, risk and criminality activated fear and anxiety amongst the group which rippled in quick succession from one individual to the next. Foster carers were observed needing to physically comfort one another and the Co-facilitator and I were left questioning

what had gotten into them that had felt so risky and unsafe. The Co-facilitator also spoke of her dissociation when these topics were mentioned, feeling tired and unable to receive what was being shared. It was striking how the children had become lost and disconnected from the foster carer's minds, substituted as adult thugs and criminals. As with my earlier reservations of how I was to fit and connect within this group, the difficulty of connecting with an unaccompanied minor when they were viewed in such a way, was notably emphasized. I was shocked to hear of the little to no training the foster carers received from social care about different cultures and the potential impact upon their home life. I could not help but question how this added fuel to the fire of anxiety and confusion.

By the end of the third session both the Co-facilitator and I began to see and feel things from a foster carers' perspective and ended the session strongly believing that FC1 could have been living with a terrorist. Although, much like my worry of my containment capacity, the Co-facilitator explained post session how she felt herself shut down and almost falling asleep during later conversations about terrorism and recruitment. Eventually it had become too overwhelming and unconsciously her thinking capacity had shut down to defend against receiving further traumatic and volatile material.

During the fifth session the group reflected upon their previous conversations and themes raised, their roles and responsibilities particularly. They referred to themselves as a *"jack of all trades"* and felt the expectations of them were unclear, conflicted, and heavy which resulted in the young person themselves becoming lost and no longer at the centre of their focus. They even branded themselves as *"security guards"* as they considered the need to protect themselves, their families, and the young people. They conversed about safeguarding, not only for the children but for themselves as professionals.

> *FC4: I think umm, more safeguarding for us actually, as a career as well, umm yeah if you take FC5's perspective of us being self-employed, if anything goes wrong, you've lost everything, you've lost your job, your reputation, you know, if you have an accusation made against you*
>
> *CF: yes*
>
> *FC4: even your status in the local community*
>
> *(some agreeing tones from the group)*

*FC4: it's gone, you know, you, you, you risk one hell of a lot for these kids and they do make quite a few accusations*

*FC3: Yeah, they do*

*(some other members agree also)*

*FC4: So, you have to, it's constant for us having that in the back of our mind, right safeguarding, safeguarding, safeguarding, but not safeguarding just for the child, but safeguarding for you*

Risk needed to be highly monitored which impacted upon what foster carers felt they could offer, as well as how close they could bring themselves to attend to and connect with the multitude of unsettling differences and unusual qualities they witnessed and felt.

Culture, Religion, and Identity

Similarities and differences of home life had an impact upon what carers could tolerate, understand and be open to when caring for unaccompanied minors. One example of this was conversations about faith and religion. The following extract depicts how FC2 tried to find common ground to enable a connection, with the Co-facilitator attempting to reinforce this.

*FC2: Well, I still talk a little bit about it and explain that, umm coz I am a Christian and I go to church and I say, I say, I show him about the common, you know the bits that are really similar. Obviously, there's bits that are really different but there are lots of parts, that are similar.*

*CF: The old testament*

*FC2: Exactly*

*CF: Is exactly the same*

*FC2: Yeah, and also just thou, and yeah like the ten commandments for example not stealing and you share a lot of those*

*CF: a lot of those are in the old testament*

*FC2: Yeah, yeah. So you know it's, it's like he always says about when they really love their neighbours so their neighbours are literally are massive part of their life and they feed each other, look after each other's children and he's like 'this is no good, why are we not having the neighbours to come around the house' (she laughs), he wanted to*

*invite the neighbours round…..We are quite private like that so we wouldn't want to have the neighbours around.*

The commonality of being religious opened a *"little bit"* of space and intrigue about the 'other'. It offered opportunities for discussions about why and how connections are made. For FC2 the commandments by which she lived her life gave it order and purpose. For the young person, it appeared to be more about connection and support. 'Love thy neighbour' was figurative to the foster carer, but more concrete for the young person. These differences in interpretation may have highlighted the need of FC2 for reservation, separateness, and privacy. Also present here is maybe some scepticism as she focuses on 'not stealing'. From the carer's observations of the young person, the want for external support, connectivity, and familiarity with how they used to live appeared important to them.

As the group continued to discuss cultural or religiously confusing topics in session four, I observed how their questions gravitated to the Co-facilitator, who had migrated to the UK many years earlier. It seemed with the uncertainty of not knowing answers to questions, the group sought clarity from the 'foreigner in the room'. This escalated into conversations laced with concerns about the threat to health these young people posed to the foster carers and their families.

*FC1: but his results came through that he had latent TB, when I rang it in, it was [social worker] at the time, she said 'you've got to lock down your house now, no one in or out'. Great! Thanks!.....coz I knew nothing about latent TB. And the medication he was on was making everything turn pink, his sweat, his urine, everything.*

The reaction to medication accentuated the 'alien-like' quality these young people were sometimes labelled with. FC2 had described earlier when trying to understand the behaviour of her young person, *"he's an alien to us to be honest and we must be alien to him"*. This 'un-human like' presentation and serious risk to health and safety threatened the foster carers and their families. Consequently, the group began to think about the poor treatment they received as professionals, the lack of choice, a feeling of 'being done too' and a want to flee from the role altogether. The Co-facilitator and I named the high anxiety present in the room. This initiated conversations about the fear of making connections with unaccompanied minors and the concern of what the foster carers felt they would be left with, physically and emotionally. In my countertransference at this point I felt dizzy and sick and wanted to get out of the room away from the group.

The Co-facilitator and I encouraged the group to consider things from a young person's perspective, their worries of losing their identities and forgetting the culture they had come from. The British culture was described as *"an unexplored terrain"* by the group as they began to consider the potential fear provoked by the threat of loss.

> *FC4: You're, definitely, definitely right I think, and, and it's natural for them to hold onto what they know and what they, you know they've been brought up and that's inherent within them and that's part of their heritage and culture and identity isn't it. The trouble is, is especially [here] our culture clashes,*
>
> *CF: Oh, absolutely yes, I can imagine.*
>
> *FC4: So, Ramadan and having to get up and go to school every day and do sports and cookery during classes and you know, it's just,*
>
> *FC2: We sort of go out, we seem to eat more in my house, we have barbeques we seem to be, like in the summer weeks, you sort of make the most of it don't we? If we have good weather, coz it's limited here we don't want to sit in bed all day on a hot day,*
>
> *FC4: Coz that's the, the, yeah they do, they become nocturnal don't they"*

Even though there was a catalyst of thought, it was laced with this persistent anxiety. The young people were indirectly described as animalistic, as if they were creatures of the night which had a threatening quality. Their night-time behaviours during Ramadan were not fully understood by the group, nor directly observed, leading to them becoming ominous and enigmatic.

Session four appeared to have a minus thinking quality to it, with inflexibility at times to be able to see things from another's perspective. Although, containment of their anxieties did allow them to be honest in how they really felt about supporting unaccompanied minors. This was confirmed by FC2's last comment, *"well that was a bit of a dumping session wasn't it, you poor ladies".* FC1 followed this by apologising then adding, *"sometimes when it's a bit tough it's really nice to just (makes a release noise)."* FC4 closed the session with her summarising comment, *"thank you for listening to all our anxieties (laughs)."* I began to contemplate what FC2 brought to the group each week, how stirring this was for others, and the influential power this had over their capacity to think, as well as my own.

Fear of Judgement and Contagions

As well as concerns about how they themselves could be impacted by the 'otherness' brought into their homes, in the first session foster carers considered how their biological children were exposed. FC1 thought about how viruses such as Tuberculosis (TB) could be spread amongst young people during the journeys by boat and FC4 highlighted the lack of vaccinations. Both FC4 and FC2 talked about the potential risk to their own children and FC2 stated she felt it was not a positive experience for her, it threatened not only her family but the likelihood of other foster carers continuing to help unaccompanied minors or take in more. With these thoughts came powerful exclaims of disgust and horror at what the foster carers felt they had to tolerate and bear witness to in "*their own home"*. At this point it felt as if the group were guilty and regretful in their decision to foster these young people, thus this internal disgust and shame was projected out onto the young people.

*FC4: but it's a bit like all the funny noises they make in the bathroom and you're like constantly, I tell mine you get away with it in my household but be careful where you do that, don't do that in school coz people will be very offended. If they start making a noise in the bathroom at school (laughs).*

*FC1: I've never had that*

*FC4: (makes hacking noises)*

*FC2: have you never heard that?*

*FC1: no*

*FC2: mine does it all the time*

*FC4: Oh my good god! (laughs loudly)*

*FC1: maybe I just don't hear them*

*FC2: they're doing it into the sink, they're doing in the bathroom sink, which is really alarming*

*FC4: it sounds absolutely horrendous doesn't it? It's every disgusting sound you don't want to hear (laughs). But then we also had that with washing, washing bottoms after to go into the toilet and splashing water everywhere.*

*FC1: Ohhh (unpleasant tone)*

*FC4: [young person] does that*

*FC2: the first time, I remember the first time [young person] had done the that I sat down on the loo, and I was like, OH, WHAT IS THAT!? It was just like a pool, sat in their dirty*

*FC1: Urgh!!*

*FC2: wastewater,*

*FC4: yea*

*FC2: and I was like oh this doesn't mix very well*

*FC4: yeah, exactly*

*FC2: its difference isn't it*

*FC4: mmm*

Their responses were summarised as *"differences"*, but it was stark how the foster carers found it so difficult to identify with these young people, who they inevitably saw as strangers which felt disturbing. The differences were just too *"alarming"* and *"horrendous"* to even contemplate or be curious about. Again, trauma appeared to be alive and active in these noises and the lack of tolerance for this; it was not a *"good mix"*. Upon reflection in the following session, the foster carers considered how these 'differences' were *"good for the family"*. It seemed that this was a rationale to deal with the unconscious hatred stirred and trigged towards the young people. These 'bathroom habits' were mentioned again in the third session, but this time with a concern of what was left behind in the phylum stuck to the side of *"their bathroom sinks".* This fear of contamination, what could be taken in and become stuck to them internally, and what they could be left with was still rife. However, FC6 again advocated for the young people who were absent from the group, *"maybe it's important to them", "I don't think they are doing it to cause offense".* Not many of the foster carers were able to engage with this perspective at the time and took the position of, *"not at my table"* and *"you can't control what grates on you".* It seemed there was a lack of capacity to tolerate and think about these graphic descriptions which were obviously very provoking, causing the foster carers' alpha functions to become flooded (Bion, 1962).

Carers were thoughtful about the large scale of differences between themselves and the young people, and the misinterpretations and miscommunications which impacted how they

understood one another and how they communicated their wants and needs. In the third session they raised concerns about how the unaccompanied young people were judged by the local community, but also how their biological children were viewed. FC4 was mindful of the impact upon her children's identities and raised concerns that the longitudinal impact of fostering could be negative and *"really affect them throughout their whole lives".* She highlighted how it was *"hard for our kids to have these differences…and they're being judged for that".* FC4 continued to describe how *"our neighbours will judge us for having different nationalities"* and *"even your wider family judge us for having different nationalities in your home".* Particularly the older generation were ascribed to struggle the most, *"my husband's nan for example, she is worried we've got a terrorist in our house".* The group appeared to console themselves by depicting their roles and experiences as foster carers as *"character building"*. However, their anxieties emerged again in the fourth session as they became enraged with not knowing enough information about who they were being asked to accommodate. Akin to the 'older generation', the foster carers were fearful of potential violence and housing children of 'terrorists'. In this disposition FC2 highlighted how she often felt she was repulsed by the young person she accommodated. Physical contact was described as 'alien' and awkward, as if having emotional attachments was frowned upon by a young person, an ethos perceived by the carers to be inflicted upon a young person by their culture and/or family.

Exploration of how social care viewed unaccompanied young people was discussed in the sixth session. It was the foster carers impressions that they were seen differently to indigenous looked after children, that they were *"easier placements"* because *"they don't drink, they don't smoke [and] they go to school".* Whereas the carers had the opposite view, making specific reference to safety plans, the difficulty of monitoring these and the sacrifices that came with this. It was felt that unaccompanied young people got put on the *"back burner"* in terms of meetings and educational input. FC5 gave a very present example of why she had turned up late to the session.

> *FC5: I've just been to a solicitors meeting and they didn't turn up. The translator didn't turn up, the social worker didn't turn up and the one before the translator didn't turn up*
>
> *FC1: The social workers never turn up, and they don't turn up at Croydon anymore.*
>
> *FC5: He's gone mad, he went absolutely berserk,*
>
> *CI: So only he has been,*

*FC5: and he's come back and saying I'm not seeing the social worker tomorrow, she not like me. She not like me.*

*FC4: yeah*

*FC5: she come this time no come, she come last time no come, she not like me anymore (said with slight accent and in broken English).*

This experienced appeared to leave the young person feeling disparaged and offended. The foster carer became angry on behalf of the young person, feeling at a loss and dejected; the shared future expectation being the social worker would not come when needed. Consequently, the foster carers felt this was another role they then had to adopt. What was enlightening to the foster carers was a parallel drawn between themselves and the unaccompanied young people. FC4 voiced that she felt, *"UAMs definitely are second class, they don't treat them with the importance that they would an English lad".* The Co-Facilitator asked in response, *"because you as foster carers of UAMs, are treated in the same category. Is that right, or not?"*. FC1 and FC4 said they had never thought about it this way before, but it did make sense and were thoughtful about this being why they sometimes felt so unimportant and unseen by services. An identity that appeared to unify them within the premise of difference and otherness.

The final session triggered feelings of desperation as the carers exclaimed how disheartened they felt. Curiously, I commented on the space we had created to talk about the celebrations and the disappointments, and how this opportunity had enabled problems, difficulties, and concerns to be given airtime and consideration. FC5 voiced the need for more space and how the group had been *"really good"* for them. This also brought some reflection about the transformation they had witnessed in longer term placements. How diversity and difference could facilitate renovation, with mannerisms and ways of life being adopted, consequently provoking a growth of shared similarities.

*FC3: Well we were going down the route of maybe adopting him, but the Home Office said his mother's in the country,*

*FC1: We tried that with [young person]*

*FC3: So, he's not unaccompanied then if his mother's in the country, but his mother doesn't want to know and he doesn't want to know his mother, he's scared. Home Office have his passport and then last week we got a year to remain letter*

*FC5: Ohh (sad tone)*

*FC3: So, we've waited 3 years and then got a letter in a year that's it really*

*FC3: Yeah, so it will break my heart if he has to go in a year. It really will.*

The capacity to take in and adopt certain differences with a mutual understanding, or at least a curiosity of where the 'other' was coming from, was curated via this group. There were indications and descriptions of several challenges to caring for unaccompanied minors, but as the group progressed the blocks to caring and thinking about these young people and what they evoked in the foster carers, became more consciously evident to them. The external space provided seemed to encourage an internal reflective space to grow where considerations about how and why connections with these young people were important from both positions in the relationship. Most prominent was the mothing role versus 'doing a job' and how this was impacted upon by how they interpreted their roles, but also how they were seen by others around them (community and family) and what they took in from the examples of relatedness presented by external services (social workers, Home Office, for example). Trauma was interlaced throughout the findings also which exemplified high anxiety levels and complexities in forming relationships. Thoughts of contamination, risks and safeguarding stirred strong defences within the foster carers which became the primary focus rather than the young people themselves. However, working through these conflicting feelings and thoughts allowed the foster carers to be in touch with the more vulnerable and sensitive parts of themselves, resulting in demonstrations and accounts of love and emerging bonds.

A non-directive approach within these support group sessions accepted the foster carers ups and downs, anxieties, anger, admissions and exasperations without judgement, vindication, or reprimand. Something they were able to adopt and internalise, reducing the guilt and shame they historically had felt. Although, having a taste of this via this research process seemed to encourage a sense of not having had enough of it previously, being without it in the future and a want for more of something similar.

## Part 2 - Interviews with professionals

As described previously in my methodology, I asked five professionals from various professional backgrounds nine questions which spanned across a thirty to fifty-minute interview, depending on the length of conversation and responses. These questions were designed to provoke thought and discussion about a young person they had worked with, or an individual piece of work which stood out in the participant's minds. The aim was to provoke their associations, impressions, observations, and practical experience. Space was also given to explore and digest these whilst encouraging unconscious thoughts or behaviours to gradually become consciously discussed. The informal structure of questioning was designed to stimulate a rapport whilst in a familiar environment, with an overall aim to encourage openness and honesty.

After coding and analysis of my interview notes, the data was grouped together into six related themes which will be discussed under the titles, Time, Working with the unknown, Difference and Diversity, Distance and Connectedness, and Whose Responsibility? These themes have within them several dimensions demonstrating the multi-layered as well as unique perspective on each topic and its importance when thinking about professional relationships and work with unaccompanied minors.

### Time

The concept of time, its value and how it was interpreted and utilised, as well as the amount of it available, was mentioned by every interviewee in one form or another. This was not limited to external circumstances, but also the internal capacity of allowing time to connect with and digest what professionally they were confronted with when working with unaccompanied minors. Appointment times, perception of time, uncertainty of place and time, waiting times, being present, ready, and willing were some of the examples apparent.

The Art Therapist was reflective about their work with interpreters and summarised how the pace of communication was something unique to the work.

> *As the interpreter was translating, I could have time to think what I wanted to ask next, usually you don't get that, it's back and forth much more quickly...I noticed how much slower the conversation was whilst waiting for interpretation. It made me think much more about what I said. Rather than it just rolling out my mouth I had to edit…it's quite nice to have some thinking time.*

Having more time to think about and reform what they wanted to ask and how this was said aloud was a positive aspect for this professional when working with these young people, almost viewed as a luxury. More attention and focus could be put towards what questions were asked rather than rushing through them in a formulaic fashion, and it allowed for some freedom of movement and curiosity. There was a thought here about interpretation, which was not solely about the process of translating words from one language to another. It seems the space initiated by translation offered an opportunity for the professional to really take in what was being said and respond with a meaningful and personalised approach.

The Consultant Psychiatrist and Paediatrician had slightly different experiences of appointment timings. They highlighted the pressures and challenges which often stirred feelings of frustration and restrictions when trying to build relationships and have meaningful conversations and interactions.

> *My [partner] is a GP and will say how difficult it is in a ten-minute appointment when there are communication difficulties. This has a complex impact upon conversations that could be and should be had.*
>
> *(Consultant Psychiatrist)*

> *I only have a short time in clinic, I should say we have an hour. It always takes almost always seventy-five-minutes. This has an impact on all of us. It would take this long without language difficulties, so we are trying to cover a huge amount of ground.*
>
> *(Consultant Paediatrician)*

Not only are there communication difficulties highlighted here, which will be explored in due course, attention is drawn also to the specific complexities these young people bring to their appointments. There appeared to be a feeling of regret about things potentially missed out and not connected with, whether that was the young people themselves or what they brought (their history, trauma, medical or mental health difficulties, for example). There was also an insinuation from the Consultant Paediatrician of the overwhelming task in allowing themselves to be open to what a young person may want to talk about and discuss, having to cover a "*huge amount of ground*" as well as a potential unconscious apprehension of what they may be subjected to hearing and/or feeling. It was interesting how the Consultant Psychiatrist introduced an example from their partner's work rather than their own, perhaps suggesting how

recalling and relating to certain material from personal experiences involving these young people becomes too close and uncomfortable, with a need to then be one step removed.

Another aspect of time considered was journeys and how long an individual might have taken to get into the UK, as well as their placement moves once they have arrived. There appeared to be unconscious references made, such as the previous extract in terms of the *"huge amount of ground"* covered, and more direct reference in the following, *"My sense is that the journey was quite quick……it took six months to get to the UK" (Art Therapist).* This extract is helpful when contemplating how we each view time, the boundaries of it and its versatility. To the professional a journey of six months to reach the desired location of the UK was deemed 'quite quick'. I was curious about what the young person's impression would have been about this, if they would have described it very differently. However, this does highlight how time is a perception and an experience. As such, it is highly subjective and open to interpretation, not just from person to person but also across cultures.

The Paediatric Mental Health Nurse attempted to put themselves in the shoes of the individual they had previously worked with and how they would have been unable to cope with the uncertainty of time and place, as well as other various unknowns. Following on from my comment about a journey not always being linear, they commented,

> *Nooo, not straight across, we will go here, we will go there, it might be days or months in one place or not knowing whether you're going to eat or sleep, or is this person going to actually do what they say they are going to do, or are they going to look after me or are they going to hurt me, ohhh no, I couldn't do that, too scary.*

For this professional the unpredictability of the length of time, dealing with the unknown and not being able to concretely place themself somewhere specific was a scary thought. This provoked a question of the capacity to be able to trust others, especially with this level of uncertainty, as well as the threat on the sustainability of life. This bears relevance to an unaccompanied minor becoming a looked after child in a foster placement or a residential service when entering the UK. Questions thus arise concerning security and settlement, will what is provided be good enough and can the young person bear to be able to internalise what they are being offered? This interviewee was also attempting to work through thoughts about their own position as a professional who would like to be able to offer more time, more stability and interactions without intentional pain or suffering. Casting oneself into a position of another may have been a way of attempting to understand things from another's perspective, thus

helping them to respond to and care for another when they cannot relate to circumstances/situations directly. However, this can become a barrier to allowing oneself to really be in touch with what the other has made of *their* experiences and how it felt to them at the time.

Professionals were also mindful of the foster placement moves unaccompanied minors experienced and how quickly things could change for them. The Consultant Paediatrician was thoughtful about emergency placements and subsequent moves and how there was truly little time to really settle. The Family Placement Social Worker had similar thoughts about quick moves without preparation time or warning. They recalled one of their first cases, an Iraqi male, described as kind and grateful but traumatised,

> *He was very, very upset when he was moved on from the foster carer. There was something about his date of birth that was corrected, relatively shortly before he moved on and he was moved six months earlier than he thought he would be moving, and it was quite a shock for him really.*

It was telling that such an example stood out to this professional, one that appeared to have shocked and possibly upset them just as much as it had the young person. Again, the unpredictability and false sense of stability of time seemed to become part of a disillusionment with the system for these young people. An unconscious pattern of retraumatising occurs which professionals are a part of and may consequently feel guilty about, the impact of which can be long lasting and impinge upon future interactions with other unaccompanied minors.

The amount of time waiting to access services and appointments was another commonality within interviews. Feelings of frustration as well as exclusion and having unanswered questions coincided with this. The Consultant Paediatrician talked about the conflict between the practicalities and ideals of their role relating to timings of assessments and follow up appointments with unaccompanied minors.

> *What would be ideal for me is to see them after two to three months after the initial assessment...so most of them would only get a review in our routine system at a year. Which is a long, long time and some of them have obviously turned eighteen, so their worlds have completely changed. We can offer, we have left it open ended so they, the social worker, foster carer can ask to see them again, but that often doesn't happen.*

Again, there is an example of this professional's perception of time and how much they felt it could change in a year. They appeared mindful of gaps in contact and wanted more of a connection to be able to follow up and check in on things, which the current *"routine system"* could not adequately permit. There was also a feeling that current policies were 'not fit for purpose' and needed to offer more which this professional seemed to attempt to fulfil by offering open-ended appointments. An open-ended agreement also prohibits the professional from leaving the young person in a state of being dropped or abruptly cut off by the service, so preventing guilt that can be triggered by this process. The age of an individual is also brought to our attention in this extract and how turning eighteen in the UK can be transformative for an unaccompanied minor. The enormity of this was encapsulated in the description of *"their worlds have changed"*, signifying the immense loss of external services and interventions available to them, but also how they are seen and viewed by others/services. This raises the question of how could this consequently alter a young person's internal world and state?

Professionals had various degrees of knowledge about services available to unaccompanied minors, but many of them noted the long waiting times before they could be accessed. Others, such as the Consultant Paediatrician, were aware of projects being developed but felt like an outsider as well as restricted by the time pressures of their job. The lack of knowledge about where they might fit and how the complex needs of these young people could be met stirred anxiety. **"***I just wish I had more time to it. I'm on the outskirts now of trauma project, but I'm left trying to work out how it will work for us. How will it meet the needs?"*. There was also something here about not being heard, much like being in the position of an unaccompanied minor, the professional felt overshadowed, forgotten and that their voice and experiences were not considered. Maintaining hope and needing to rely on others to fulfil specific roles or meet certain criteria was also contemplated by the Paediatric Mental Health Nurse,

> *I didn't work with him for long because I changed my job, but what was done was we hopefully equipped the foster carer to speak to him or allow him the time, the permission to talk about what was keeping him up at night….*

It seems here that permission was dependent on time, preparation, and a certain level of tolerance. The professional appeared to have given the responsibility to the carer who needed to be available and have the capacity to provide time and space to listen which the professional could not. The professional's opening of this comment may be an unconscious signifier of a need to distance and move away from the subsequent work she describes.

Communication was illustrated as a two-way process by interviewees, with a young person needing to feel ready to share and a receptive adult who was willing and able to receive what was being conveyed. The Paediatric Mental Health Nurse was thoughtful about referrals into CAMHS and how this had become a part of an unaccompanied minor's process through the system. They accentuated that it was not always the *"right time for that child"* to be offered a space to talk about what has happened to them. *"They may want something when they know they are staying…there then is a pressure upon us to make it the right time even when it isn't".*

The length of time it can take for a traumatised young person to want to talk and the implications this might have on both the young person and the professional when this is forced or rushed resonates here. Another question arises, who must be ready for what and where does the pressure come from in terms of timings and for it to feel manageable? It also highlights how permanency, security in an environment and relationships were paramount for building trust so things can be shared.

It was interesting that the process of collecting data via interviews also resonated with the theme of time. When approaching various social workers, emails were either not responded to or answered weeks later with an explanation of a busy workload or limited time. The cancellations I encountered and the need to reschedule were also at short notice, with an explanation that their time was required elsewhere, or they had lost track of time and thus my request. It appeared that time given to thinking about the impact of working with these young people was hard to cultivate and protect.

When interviewing the Consultant Paediatrician, from the start they communicated they were pressed for time and responded to my email with an enquiry of how much time I would need from them. When the interview then occurred, the office door was left open for the first few minutes and we were interrupted by other members of staff. I also felt in the transference that I became one of the many other initiatives that had gone on before, *"I've been around long enough to know that by the time the right people find out about it or join in, the initiative has gone"***.**

This resonated with me, as it was my final interview, a few weeks before my training placement was due to end and I was moving on. My name, position and research were only just becoming known about and there was already a feeling I was disappearing, just as more thought and attention was being paid to the area. The Consultant Psychiatrist concurred with this perception and gave encouragement for taking on the task and the time to document this topic, *"We are*

*not very good at writing things up and spend a small proportion of our time doing these things. They are helpful for improving services so it's a good thing you are doing".*

**Working with the unknown**

Another theme that appeared in conversations was how professionals dealt with not knowing or being unsure about the details of who they were working with. There was also uncertainty about what external services were available and they questioned their own abilities and tolerance levels to be able to work professionally with this volume of unfamiliarity. Some were mindful of how this level of ambiguity felt for the young people themselves, their missing histories, the unknown threats, and risks, and what their capacities to stay with the unknown might be.

When an unaccompanied minor comes into the country, they tend to arrive with limited information about themselves. We may assume this is because information and identification documents become lost, are stolen, held by traffickers, forgotten by the individual or purposely left behind for one reason or another (no time to locate or because of potential links to criminality, for example). The point is we do not know, and interviewees were thoughtful about this. The Family Placement Social Worker when comparing their work with unaccompanied minors to looked after children, highlighted how unaccompanied minors may come with a first name and an approximate age but nothing else, whereas looked after children enter care with *"a lot, lot more"*. An unaccompanied child's lack of personal possessions or limited number of them, does not assist with confirming the accuracy of the details provided either. This can leave a professional feeling hopeless and at a loss,

> *Their name and date of birth, both are usually incorrect. We might get told where they come from, but no background of where they are from.*
>
> *(Consultant Paediatrician)*

> *I haven't had one that has come with fully documented immunisations. We have to start immunizations from scratch.*
>
> *(Consultant Paediatrician)*

The image of immunisations stayed with me after reading these comments during analysis. It was as if the professional had been confronted with a new-born baby with no identification tags or knowledge of their previous immunisations, an orphaned baby in an adolescent/adult's body.

Thus, the potential unconscious infantile anxiety aroused in this dynamic could have added further complexity to the communication with not only the individual in front of them, but also with what is stirred internally for the professional. The ambiguity of no background knowledge and this feeling of starting from 'scratch', highlighted the painful conundrum professionals may face when they try to identify a young person's needs, much like that of a surrogate mother. The only way to manage the overwhelming nature of cases such as this may be to focus on the body instead of the whole person being thought about. Focusing on a symptom or an issue such as immunisations becomes a way of not getting too involved in the care of the patient and a means of managing the professional's defences and dulling any familiarity.

An anecdotal account from the Art Therapist provides another example of how the lack of confirmation regarding identity can impact upon the decision-making process for professionals. A conversation with a social worker colleague depicts an arrival scene at the port,

> *They had gone to meet I think there were 5 young people, who were found in a freezer truck and they had been in a freezer truck for hours...They had loads and loads of clothes on, they said it looked like they had just gone and robbed a few washing lines kind of thing, a right mish mash of clothes, where they have heard of people coming in proper ski wear, these hadn't. So, whoever took the money for transporting them did a shit job on these 5 people. They were seen by ambulance crew, who said subject one, two, three, four, five. Subject five had a very low body core, life threatening body core temperature, but then they couldn't say when the social workers arrived, they didn't know who was one, two, three, four or five. So the person who needed hospitalisation for the low body temperature, they didn't ask a name. And of course, they are all disorientated because they have been in a truck and they're frozen, so their thinking was all of that, so nobody asked for a name…*

The vagueness in this account is striking, the unknown quantity of time the individuals had been travelling in such conditions, the names, and identities of the young people, where they had taken the clothes from, as well as who had arranged their transportation and where they were from. The description of the 'mish mash' clothing encapsulates the complexity here and the confusion these young people not only had themselves, but also what they were potentially faced with upon meeting professionals. Freezer and frozen are mentioned a few times in this extract and I think emphasises how this ambiguity impacts upon the ability to be able to continue thinking, both for the young people and professionals involved. It could be that the

level of risk and life-threatening circumstances triggered the defence mechanisms of the professionals, consequently restricting space for connectivity which led to numbering them one to five which depersonalised them. Like the previous extract, there seemed to be hopelessness and a paralysis on thinking, cultivating disorientation. Anger seemed present for the Art Therapist, who cursed and expressed hostility about the advantage taken of these young people's vulnerabilities and anger sparked by the mirrored abuse from *'whoever took their money'* and the negligence of the professionals who were unable to obtain a name when faced with the shock and horror of what they were uncovering.

Not knowing may lead to feelings of mistrust for professionals, who like the Consultant Psychiatrist questioned how they could deliver care and engage therapeutically with these young people with so many uncertainties.

> *What I find particularly tricky is, again going back to the communication and what is their understanding, what is the medication actually going to do, how do we communicate and understand each other where we stand, what is my agenda of providing the medication and what is yours in terms of outcomes…Then is there a family history in terms of ruling out this and that and the possibility of risk elements associated with prescribing.*

Even though concerted efforts were made to gain consent, certainty and clarity verbally, it was felt that even the interpretation of language could not be trusted, *"How do we know for certain what they are saying, due to the interpreter yes, but still we don't feel comfortable"*. The Consultant Psychiatrist highlighted their ambivalence when working with unaccompanied minors and the potential risks not only for miscommunication and misinterpretations in general and in this instance when prescribing medication. It was as if something trickier and more malevolent was hiding beneath the want for help and medicines.

It is evident that the need to protect oneself was the norm, but these defence mechanisms and sources of scepticism appeared to stimulate fear regarding potential threats and terror. Extremism is an external reality that professionals are trained to try to identify, but this may reinforce how impractical it then becomes to have an organic therapeutic relationship, which requires trust to survive. When both parties feel they must be cautious and where neither feel safe, their internal realities may become tarnished and primed not to allow a connection with such a potential risk. Considering this level of threat and a need to keep oneself safe and

professional, raised the question of how these young people are kept alive and held in mind by professionals. The Paediatric Mental Health Nurse talked about their struggles with this,

> *I'm now wondering what has happened to that man…I hope he isn't drug dealing and hope he is alright. That's the thing about the job, we don't know after the piece of work. I wonder where he is, hopefully OK up North with his uncle, I don't know. I wonder who is thinking about him back home, is there anybody thinking about him? At this moment in time, I am thinking about him, but he doesn't know. He's probably forgotten that I exist, but I am wondering and worrying about where he is, but there's nothing I can do about that.*

There was a want to place the individual somewhere familiar, with family and somewhere the interviewee could visualise, rather than feeling completely hopeless. Here it seems this professional questioned what they were able to offer within themselves to this young person, whether they had been a 'good enough surrogate mother'. There was also a suggestion of whose responsibility he was now, as well as maybe some relief that he was no longer theirs.

The issue of personal tolerance when working with such unknowns and whether there was an availability to give this a space to think about was also mentioned, *"Should we know more?! I'm unsure people have the capacity to because there are so many different cultures that people are coming from. Only through working with people do we get a greater understanding" (Art Therapist).* There appeared to be a thought here about personal capacity and the threat of being overwhelmed and invaded. This extract also raises an important point that, only by facing these difficult facets and being in touch with them can one really know how it feels and what we might need to bear.

When asked about the statistics of how many unaccompanied minors there were in the UK and the local area, interviewees had mixed views. Some felt they had no idea and sought information or reassurance from me, others attempted to guess, which appeared to stimulate feelings of vulnerability and exposure,

> *I don't know the statistics, I don't know the numbers, but I don't think there's very many. I don't think we have this huge influx of children; I think there's enough, there's too many, there shouldn't be that many. Umm… I'd probably say about 10, 20 maybe, 20 max., I'm generally making it up, I have nothing to base it on* [4].

[4] *(Her pitch gets higher gradually with every guess, signifying some potential uncertainty and anxiety).*

*(Paediatric Mental Health Nurse)*

Following sharing the government and locally sourced statistics, it was interesting to see the divided responses. Some felt the figures were trivial, lacked context and dehumanised the young people they were about, whilst others appeared to feel invaded and threatened. These varied responses also indicate a professional's internal capacity, as mentioned previously, which appeared threatened by overburden. A certain percentage may seem higher and more intimidating to someone with a limited capacity to engage with such material, whereas someone who is able to bear more internal unrest and contain this, may view the same numbers with less fear.

Some professionals were able to relate to how hard it may be for a young person to lose contact with family members and consequently have no knowledge of their whereabouts or wellbeing. Safety plans, which will be discussed in more detail shortly, were felt to a be a contributing factor to this, with young people having their means of communication stripped from them and no knowledge of where they themselves were being accommodated. The Art Therapist spoke of a young person who had been separated from his brother and he wanted nothing else from services but to locate and be put in contact with him. The Art Therapist was empathetic with how hard this must have been for him. The Family Placement Social Worker was thoughtful of how other's perceptions of not knowing impacted upon unaccompanied minors,

> *Black African refugees and unaccompanied minors that are coming over here, they have themselves said that people look at us, not so much if we walk out one or two of us, but if it is a group of us going into a shop they were looked at as if they were there to cause some sort of disturbance or maybe steal something. I'm not sure if they were looked at like that, but that's the way it feels.*

It seemed when faced with uncertainty, unfamiliarity, and gaps in our knowledge, it becomes filled with preconceptions, connotations, unconscious bias, and a ready-made template. In this scenario the group may be serving as a source of protection for the individuals who were a part of it, but to outsider's it was a perceived threat. This will be explored further in the section 'Difference and Diversity'. When discussing this topic, the Family Placement Social Worker switched between talking in third person and first person, perhaps illustrating how she was attempting to understand and be in touch with how these experiences felt for these young people. Maybe, this also illuminates how powerful feelings become projected from these young

people into professionals which they then possess as their own. Boundaries thus become blurred and distinguishing what belongs to whom becomes the unknown.

Many of the interviewees saw the interview process as a positive experience where they could explore and find out more about the subject matter. The space allowed them to be in touch with this idea of 'not knowing' and for this to become more conscious to them, *"I've realised what I don't know" (Art Therapist)*. For some they were able to stay with this notion of consciously not knowing, for others they needed to seek further information and clarification. For example, some wanted to seek further information about external services that were available, potentially to aid with the uncomfortable reality of not having the answers and for someone or somewhere else to locate this. The Paediatric Mental Health Nurse drew attention to how difficult it can be to engage with unaccompanied minors when there is so much suspicion. They specifically emphasised how interpreters were sometimes viewed and the concern of what would get passed to whom in terms of information, *"everyone seems to know everyone"*. Here the concern was about confidentiality and whether information would be taken and used elsewhere by the interpreter. It provided another example where trust was questioned and infiltrated the alliance, this time with an interpreter. This comment was also poignant when considering what it might be like to be a participant and the unspoken anxiety relating to where and how the data collected might be shared and read. Although this was clearly discussed and confirmed with interviewees before gaining written consent, suspicion seemed to be present in the dyadic relationship between interviewee and interviewer too.

**Difference and Diversity**

Personal bias and prejudices when faced with difference was something most professionals were open to exploring, although their ability to personally be associated with this differed. There was some awareness of conscious and unconscious re-enactment, as well as thought about how various religious and cultural views impacted the ability of young people to seek and accept mental health support. Unconscious and conscious bias, colour, and gender, Looked After Children (LAC) vs. Unaccompanied minors, religious difference, and the perception of mental health are all sub-themes explored within the overarching theme of difference and diversity.

The Paediatric Mental Health Nurse spoke openly about the need to acknowledge prejudices to avoid them getting in the way of processes and assessments when working with unaccompanied minors.

> *I have to be really aware of my own prejudices, whether we like it or not we carry a belief system in with us, as much as I'd like to try and be empathetic. I know I've got the Daily Mail in the back of my mind; I try to not let that come into the forefront of my mind…I think probably 10% is like that, I'd say sceptically curious. But the other 90% would be empathetic around it…otherwise I wouldn't be able to do my job. I have to really check myself to get rid of something that might be preconceived or inaccurate. Without you realising I think you do subliminally soak in a lot of the messages that the government might want us to think, or our friends, or my family. It subliminally sinks in there and you might not be aware consciously that it's putting a judgement on, but it might. That example of a group of black boys walking down the road, 'oh they might attack you'. They're probably minding their own business but that preconceived idea that they might attack you.*

The acknowledgement of an internal belief system cultivated via relationships with family, friends and other sources is important here and exemplifies the complexities of interactions, especially when belief systems may operate unconsciously. The possibility for clashes and contradictions becomes elevated, consequently contributing towards feeling threatened and persecuted. Normal curiosities become laboured with scepticism and delivered with caution, with this professional preparing themselves for what they may be opening themselves up to, what might they see, hear, and thus become in touch with. The percentage divide seems to acknowledge the need to hold some self-preservation, to keep a part of themselves inoperative and safe. Additionally, it links with this notion *'to get rid of something'*, an uncomfortable and undesirable part of the self the professional does not want to own, nor they want to acknowledge fully exists and a split within the self occurs. This fragmentation and the desire to keep these parts unknown, grants access to external ideas and concepts filling and connecting the gaps. This links with the idea of 'sinking in' and the absorption of such things as media views, which offer segments to fill the missing pieces of the jigsaw of our understanding. Judgements about potential threats and preconceptions are thus already shaped, rather than allowing oneself to be open minded without the need for armour.

The Consultant Psychiatrist concurred with these thoughts. Social media was considered a platform where assumptions and prejudices fed into judgements which unconsciously pushed *"you to become biased about certain things"*. The Art Therapist used the term *'unthinking racism'* to describe a behaviour or action an individual might enact when complexities of race and integration are not fully thought through, with the potential to cause more damage or offence than is intended. The Consultant Paediatrician, due in part to working abroad and undertaking specific training, was able to be in touch with their more conscious bias, attempting in their work to be aware of *"cultural things"*. However, they identified they had *"made some howlers"* and *"recognised how offensive"* they could be. Non-verbal gestures as well as touch and eye contact were thoughtfully considered and what could be deemed rude. They were also mindful of how previous experiences with individuals from certain locations inevitably formed predispositions which could taint future interactions,

> *I'm probably quite biased towards Albanian's because they are the ones previously that we have had, well some have been trafficked, but there's also a lot of economic migrants, who have then very quickly got into gangs and exploiting others, LAC and local kids. I do try to recognise that I am positively predisposed to a Sudanese than I am to an Albanian.*

Difference in skin colour was a subtle thread which weaved in and out of the discussion of difference and diversity, mainly brown, black and white mentioned. As in previous extracts, there are ideas that 'black boys' held a threat to those who were white or different to them. White skin colour was mentioned, but it was the attire 'white boys' wore that held the threat, not their skin colour. Many of the professionals felt the media supplied messages regarding colour and race subconsciously, encouraging a view that all should fit into one category; *"You have brown skin you must be the same and I know that's not true" (Art Therapist).* Others were thoughtful about what it was like for unaccompanied minors coming into the country,

> *They're persecuted by the people that they have left and persecuted by the people they have come to. I feel really, really sorry for anybody of any other colour that comes into the country…as long as your white and you speak English it seems, oh that's ok.*
>
> *(Paediatric Mental Health Nurse)*

> *[Here] everybody knows everybody, and they can quite easily see who hasn't been born here.*

*(Family Placement Social Worker)*

Although the second extract does not directly mention colour, it highlights the perception of difference and dissimilarity, as does the first. If an individual can blend in and go unnoticed then this seems to be an advantage. Again, linking in with previous discussions, there was a subtle question of where feelings of persecution are held, within the unaccompanied minor who may feel they are seen as different, or in the 'other' who feels intimidated by difference?

The Consultant Psychiatrist pulled colour into the conversation in an interesting way, *"…and equally you don't want to take coloured glasses that all asylum seekers are potential terrorists".* The use of 'coloured glasses' was thought-provoking and exemplified how the threat of difference and the unknown was possibly tainted unconsciously by colour. Additionally, it illustrated the professional struggle to remain neutral and unbiased when there are potential risks and/or threats perceived. Some professionals felt unsure of how to approach the differences they met, which was unsettling for them,

> *I don't know what else there is and also know that the young people come from so many other different places, I am a bit wary of saying you're an unaccompanied minor you go there. I'm unsure of all the differences between the Sudanese, Shia, Sunni and not confident to say or recommend.*
>
> *(Art Therapist)*

When thinking about other services, locations, and individuals that unaccompanied minors could connect with, the Art Therapist shared how unsettled this made them feel. Rather than feeling free to be as curious as they might be with other children in their work (looked after children in particular), it appeared they were almost overwhelmed by the uncertainty of difference, unable to explore it and wary of offence that may be caused. Others identified that it was often much harder for unaccompanied minors to access services due to their level of status which was perceived as much lower compared to others in society, so access was either denied or limited. Again, a professional's internal capacity to identify value and see worth, encourage closeness and relatedness was laced with potential threat.

Professionals seemed divided about the variances and comparisons between looked after children and unaccompanied minors. Their attachment styles were compared, with a preconception that many unaccompanied minors would have had an experience of secure attachment relationship, whereas this was unlikely for many looked after children. Some

viewed their experiences of trauma as different, with many looked after children experiencing adverse childhood experiences, such as abuse, neglect, deprivation, and loss early on, whereas unaccompanied minors' experiences were perceived as environmental trauma and loss which was more recent. These young people were viewed as disadvantaged, akin to looked after children, but with added resilience and a solid and robust internal scaffolding which equipped them to manage such experiences. *"Like any LAC or any child with no voice, I am passionate that they have a voice and recognise that they are a disadvantaged group". "They are an incredibly resilient group that you don't get with our local kids" (Consultant Paediatrician).* However, this stance places young people into homogeneous groups against one another rather than viewing them as individuals who have had different experiences of being loved or abused, for example.

One feature that definitely set unaccompanied minors apart from looked after children and professionals alike, was religion,

> *Religion is the one thing that becomes a significantly sensitive issue for a vast majority of clinicians and the rhetoric around these are potential future extremist and that is something we are always conscious in our mind are we going to be very mindful of our training to identify whether there are any risk factors or vulnerabilities which make this particular individual a high risk, hence why it immediately comes to my mind. I think it's not necessarily a very professional kind of position because it's not all about them being risky to others, it's about them being vulnerable as well. The vulnerability also increases the chances [of being radicalised] as well.*
>
> *(Consultant Psychiatrist)*

Here the complication and professional conundrum appeared to be how could these young people be protected and have their needs met, whilst upholding a professional boundary and protective stance. The sensitivity spoken of appeared to lie in the authenticity of religion and religious beliefs, as well as the potential for a perpetuating cycle of risk vs vulnerability interwoven with possible exploitation and manipulation. This conceivable impending reality held a threat because it could not be predicted nor entirely controlled. There was recognition from the Family Placement Social Worker of how some young people (Iraqi and Afghani young people in particular), turn their back on religion and struggle to identify with its teachings and way of life upon seeking asylum in the UK. As with the views of Consultant Paediatrician, they felt Sudanese young people's faith was more integral to them. There were

curiosities about the struggle of coming to a new country and potentially into a foster family, and how you hold onto an identity, morals, and beliefs. In parallel, how do you as a professional and carer, support an unaccompanied minor who you see changing and adapting in their views, potentially shedding what they once identified themselves as? This raised the question of do you support them and see this as a process of acclimatising, or consider this with caution and alarm as their belief systems shift and their religious orientation transforms?

One other difference mentioned were views on mental health and seeking support. The Consultant Paediatrician raised how professionals should not expect unaccompanied minors to have the same attitudes to health care as some indigenous families do *"…hospitals were where you went to die or with extreme illness. Maybe in Albania, but most of them won't have your traditional health clinic or doctors. It's the absence of health when you think about it".* The Consultant Psychiatrist's account corresponded with this notion, adding how psychiatric medication had become less stigmatised in Western culture over the years compared to many others. *"There are many unaccompanied minors coming from a potentially conservative society who have significant stigma attached to mental health issues…medication as an intervention is difficult to accept".* This indicated how tricky it can be for professionals to connect with an individual who has not had an experience of considering their mental health as a significant feature to maintain and cultivate; especially when there may be feelings such as shame and disgrace evoked when doing so.

**Distance and Connectedness**

Proximity was another theme which arose during conversations with all interviewees, with thoughts given to the internal conflict between professional engagement and personal relatedness. There were attempts made to understand experiences from an unaccompanied minor's perspective, placing themselves in their shoes. Additionally, loss and being separated from significant others were further dimensions professionals were considerate of, as well as what it may be like being within a foster care relationship.

Both the Art Therapist and Family Placement Social Worker drew attention to the struggles of placing unaccompanied minors and the initial reluctance in caring for them. When giving an account of their work with a foster carer, the Art Therapist recalled, *"She does struggle to like him as much as the others she is caring for that are more settled and socially adept"*. There appeared to be a difficulty to connect with those less sociable or reserved, perhaps, stimulating

concerns about what was not being shared and why, or even provoking feelings of rejection in the foster carers.

This distance encouraged a need to pursue connectivity elsewhere, such as seeking advice and support from services like CAMHS. The Paediatric Mental Health Nurse gave an example of a referral received from a foster carer who was concerned about the apparent difficulties a young person had in being able to articulate their trauma. He was described as, *"just getting on with things and being quiet and she was concerned he was masking things".* Their concerns were exacerbated by his age (soon to turn eighteen), when he would no longer be in foster care, nor be able to access certain services such as CAMHS. This appeared to add to the foster carer's feelings of guilt and concern of not having done enough, thus this was a last attempt to try and support a connection for the young person. At the very least, it appeared to role model an attempt for connectivity. The professional was mindful of the pressures and sometimes limited time in foster placement, combined with a sense of overwhelming need from the young person. This may have prohibited the carer fully appreciating whether the young person was ready and in the right state of mind to want to share such emotive content. Other case examples recounted mentioned foster carers requesting a formal diagnosis to explain behaviours they observed, and I considered that pathologies, labels and diagnosis may be used to create distance from the impacts of trauma.

The Family Placement Social Worker highlighted other areas of difficulty within the care environment perhaps adding to these troublesome feelings for some foster carers,

> *It would be really helpful if foster carers could have telephone interpreters once a week….to help with communication difficulties. There is often a lot of misunderstanding...they will then wait for the Social Worker to come out after a few weeks with an interpreter, but by this point this has had quite an impact upon their relationship.*

It was not clearly distinguishable here who needed the support, the unaccompanied minor who was unable to get their point across due to linguistic restrictions and difficulties, or the foster carer who became confused and unable to receive what was being communicated. Again, this highlighted the toing and froing between a want for connection and then a disconnect which causes rupture and frustration in a relationship, limiting the capacity to want to engage and willingness to hear and understand from both sides.

The Paediatric Mental Health Nurse and Consultant Paediatrician commented on their observations of the care offered to unaccompanied minors, its advantages, and its limits.

> *They were a well-known foster carer to the service and known for being motherly, they would become very involved, in a very nice way. They wanted the best for the young person who had stayed with her…She was concerned he would drift through and disappear.*
>
> *(Paediatric Mental Health Nurse)*

> *Some fantastic ones that are showing huge amounts initiative and are working beautifully with them. They become a part of the family. There are others that are stuck in a room and not integrated in the family at all which is not acceptable and very sad.*
>
> *(Consultant Paediatrician)*

Both extracts contain aspects of disappearance and concern about distance, where something was not seen or linked up either from a protective stance or from a wish not to be seen or to see. The Family Placement Social Worker highlighted how many foster carers they worked with could overtime begin to see there was, *"actually quite a lot to learn from these young people"*. Although there were many examples of the worry and overwhelming nature of the work with unaccompanied minors, there were positives and advantages from interacting and connecting with them personally. This was not merely what could be learnt about them and where they were from, but the process of engagement and connection was described as a fruitful one which was enlightening for the self.

The Consultant Paediatrician was thoughtful about the internal displacement some unaccompanied minors experience in their home countries before they have even begun their journeys. This raised a question of what does 'a place of safety' mean to these young people and how does it then feel to potentially encounter further displacements, uncertainty, and lack of control within these places of safety. Safety plans are regulatory for an unaccompanied minor coming into foster care. The Family Placement Social Worker explained how young people were usually on these for four to six weeks and the implications these can have on a young person. *"They are no longer able to go out on their own…they've travelled to several countries and suddenly they can't even leave the house for ten minutes on their own".* In the same vein, the Consultant Paediatrician considered how this disconnect and restriction of autonomy may feel for a young person,

> *Generally, if we are seeing them within the timeframe, which is twenty working days, they are almost all still on their safety plan. And that has huge implications…they've lost their communication with the outside world, so their mobile phones, and their liberties are hugely restricted.*

As with the Family Placement Social Worker, the restriction and limits described felt sudden and harsh. The clash seemed to be between how an unaccompanied minor was viewed by Western standards, against the reality of what they may have experienced and faced, where they have conceivably witnessed and dealt with things far beyond what would be deemed 'normal' for their chronological age. Paradoxically, it seemed they were now being protected from what they had already experienced. Contact with all familiar sources were cut off and perhaps exacerbated feelings of isolation, with a loss of the privilege of owning and using a phone, not knowing where you live, nor having the freedom to travel. The Family Placement Social Worker added that the UK did not give the best response to unaccompanied minors arriving into the country, *"…They are seen as independent in their own country, here they feel patronised and treated as a child again".* There is a contradictory message sent to unaccompanied minors entering foster care, a request for them to open-up and share whilst stopping and restricting communication and access. To some this may be incredibly confusing, unsettling, and belittling causing the foster placement to commence on a fractious and detached footing.

The Art Therapist was mindful of one case, briefly touched upon earlier, where separation and loss were aggravated by having no means of external communication. A young man had initially travelled with his brother, who he had been separated from on the border of Turkey. His main preoccupation was to find his lost sibling. He knew of a cousin residing in Manchester, but due to having his phone removed all information about him was inaccessible. The Red Cross were supporting him to locate his brother, but the process was slow and excruciating for the young person. There was a concern from his foster family that he was not dealing with the trauma of his past. The involvement and work from the professional was to support the foster carer to increase their capacity and understanding that a trauma could not be digested and thought about reflectively by the young person when it remained alive and active in the present.

Other professionals observed the need of these young people to link up and connect with one another,

> *What I find interesting is how they team up with each other, they are very determined to get what they want. It is interesting how the foster carers are reacting to that. All the young people know each other, so if one gets glasses then the other will want glasses…it's the same with new iPhones.*
>
> *(Family Placement Social Worker)*

This determination for alliance conveyed a want for connectivity and clarity, whilst coming together in a group to promote feelings of unity and identity formation to evade loneliness and assert an identity rather than to not belong at all. Teaming up and a gang like demanding nature was perceived by some as aggressive. The Consultant Paediatrician used their previous experience of working abroad with *"street kids, orphans and displaced children"* to understand this 'feisty' behaviour as a survival instinct, to keep others at a distance. They also referred to the *"block on care"* that can occur in health systems. An example of NHS numbers not being assigned for up to a year, causing potential delays and prohibiting access to interventions and treatments was one example of this, disbarring another form of connectivity.

Professionals were mindful of how they engaged with unaccompanied minors and the need to remain proficient in their work and interactions with them. However, it was interesting to note during the interviews how some struggled to engage with questions, seeming uncertain and slightly anxious about what they were being asked. The Consultant Psychiatrist spoke of the *'tricky'* nature of the topic and my questions. There was uncertainty in their response when asked for their associations (question five), as if I was trying to deceive them. Their answer left me confused and bewildered and the professional second guessed whether they had given me what I wanted. Comments such as *"hard to capture"* and *"vulnerable"* were mentioned in subsequent conversations linked to statistics and expectations. The latter part of the interview felt rushed, and it became evident that I had succumbed to an unconscious pressure to complete it quickly. Upon analysis of the data, I realised I had not asked question seven. There was a powerful unconscious sense of hopelessness, enough to prohibit us both from engaging in any active thinking about improvements or changes which was the topic of this question. One of the final comments; *"it doesn't fit in with the modern way of working"*, perhaps suggested how hard it was to find a space to tolerate all that surrounds these young people, what they bring to appointments and interactions (both consciously and unconsciously), and some admission of defeat.

The Art therapist used their work with looked after children as a strategy for working with *"people who are difficult to engage"*, whilst the Consultant Paediatrician emphasised how awkward some interactions could be. There was consideration given to basic human behaviours and communicative exchanges to decipher whether a young person's behaviour was learnt and associated with cultural influences, or if there was a need to dissociate and evade as a means of self-preservation to protect oneself in fear of re-traumatisation.

> *Eye contact is another thing…the chap I was telling you about, the really traumatised one, he was hard to comfort because he would avoid eye contact. This may be culture but also fear. With another kid I might touch to give reassurance and that is a no, no. Some others will invite it.*

The complexity here seems to be multi-layered, with distance and connectedness being heavily influenced and dictated by not just cultural background, but by the trauma experienced too. This did not deter this particular professional who still endeavoured to offer some sort of connectivity, *"We need freedom from the screen and paperwork to be able to look at their faces and see what the interpreter has said doesn't register and caused huge offence" (Consultant Paediatrician).* I was struck by how the senses were unconsciously drawn attention to and gathered in these last two extracts, where what is heard, felt, touched, and seen, linked to the efforts made to try and connect with and understand. However, the Consultant Paediatrician reminds us of the potential to *"cause offence"* and restrictions put in place, such as screens and paperwork, may act as ways to preserve separateness and limit insult, but also connectivity.

Each professional attempted to place themselves either in the position of an unaccompanied minor or those who care for them, before reflecting upon how their own personal characteristics were perceived. This stimulated various feelings in each of them,

> *I try to imagine, looking though my front window sometimes and seeing the houses not there anymore, how would that change everything about my life and my relationships…this is what people have coped with. Putting me and my son in their shoes…what would I do, how would I manage with no money, people being horrible to you, you have to wear this, don't do that, don't do this.*
>
> *(Art Therapist)*

*I put myself into the position of the Carer and the possible dilemmas…expecting the young person to say please and thank you's for example…I need to work with the carers to help them understand cultural backgrounds.*

*(Family Placement Social Worker)*

*If my home life was good, I felt loved and secure, there was no rape or war, I'd want to stay. I wouldn't want to risk my life in a little boat or give so much money to these people and risk my life. I kind of then balance that. You wouldn't want to leave somewhere you felt ok in, it must be bloody awful there…I can't imagine if it was the other way around, how scared and alone I'd feel. I wouldn't have the guts to leave at all.*

*(Paediatric Mental Health Nurse)*

*One of the benefits of me being an immigrant myself is they can somewhat relate. So, I find actually 'You're like me' kind of relationship, which is very useful in terms of breaking the ice and them being very honest. That helps in terms of engagement and the narrative and story and to a degree an understanding of the cultural differences which they may present with.*

*(Consultant Psychiatrist)*

*I have a background interest because I have worked overseas, I have worked in Africa mostly. So, when they started coming through, I welcomed it rather than being fearful of it. It comes fairly naturally to me and in that way, I have been the foreigner in various countries.*

*(Consultant Paediatrician)*

Both the Art Therapist and Paediatric Mental Health Nurse attempted to place themselves in an unaccompanied minor's position asking how they themselves would cope and manage without familiarity, questioning what it would take to leave this behind. This was something which was highly emotive for them as they tried to contemplate the fear, isolation and change in relationships because of invasion or loss of trust. There was also some thought given towards pressures externally, and possibly internally, to conform to new environments and demands. The threat and risk to life was also repeated.

The other three professionals were thoughtful about difference and ways to understand it. The Family Placement Social Worker was mindful of the gap in knowledge and understanding of difference in others, with a desire to promote thought on the topic. While both Consultants were interested in 'backgrounds' and relating, identifying a foreign part of themselves as they felt this promoted connectivity and engagement with others who were also different. It is interesting this idea of a possession of something like the other, there being a match, or being in someone else's shoes, where there is the potential to insert one's own reality which avoids listening to, staying with and connecting to the trauma experienced. However, there could also be a counter argument that this aids the process of digestion, to internalise and own something as part of the self, engaging with it to enable meaning-making. The Art Therapist illustrated how painful this process of connectivity from a personal perspective can be, *"It's hard talking about how does it affect me. I was getting a bit upset which doesn't surprise me, I just noticed that in myself."*

The Family Placement Social Worker and Consultant Paediatrician positively referred to the investment of time and money to *"great projects"* involving unaccompanied minors, my research included under this umbrella. However, they highlighted how little hope could be instilled in a process which had a familiar history and pattern of lost engagement and isolation, leading to desertion. This linked to the position of untrustworthiness and obscurity professionals often find themselves in when working with unaccompanied minors, questioning whether work can begin, and can a connection really be made when the individual is likely to 'disappear' or move on. However, the Consultant Psychiatrist was keen to get my findings heard and noticed, encouraging me to present at the Trusts Research and Improvement Conference.

**Whose Responsibility?**

Some professionals found themselves deliberating a quandary of what their roles encompassed and what they had to offer when working with unaccompanied minors. *"I don't see it as my responsibility to solve the problem but at the same time I do have a lot that I could do to help other people" (Art Therapist)*. Consideration was given to what services should provide what, whose roles met which needs, what was deemed a personal or societal responsibility, and how little control an unaccompanied minor had in these negotiations.

The battle for professionals working in CAMHS was whether an unaccompanied minor's presentation could be defined as a mental health difficulty or whether it was a 'normal reaction'

to the trauma they had experienced. There was some uncertainty of how they could be worked with directly and where they sat within a service. The Art Therapist explained, *"Of course, they are traumatised, but we can't work on that immediately, there needs to be some sort of stability, from school, placement, and that the young person wants this too before we can start working on the trauma".* An experience of stability was considered important before engagement with trauma via direct therapeutic work. In addition, it was important that the young person themselves felt ready for this work, not because there was a need coming from elsewhere. Other professionals had reservations about there ever being a period of permanency where this work could ensue. The Paediatric Mental Health Nurse contemplated the different levels of trauma and how the continued movement between and abrupt losses of service provisions, could potentially traumatise them further,

> *Foster carers aren't as nice as they should be, and there are false promises. There's always someone usually championing for the looked after children, but an unaccompanied minor is usually on their own, there are not many people championing their cause.*

Within this extract there appears to be dissociations and projections into the foster carers by the professional, especially with their closing comment in mind and the potential guilt conjured, *"…there are those judgements that go on and maybe I should be a bit kinder to people".* This notion of false promises was perhaps an expression of the discomfort at what this professional felt they were unable to offer, or that the service could not fully commit to. They also raised the point of advocacy and isolation which was similarly picked up by both Consultants. The Psychiatrist saw Social Workers as having a key role in providing this, whilst recognising that not all young people were lucky enough to receive it, thus having to manage alone. The Paediatrician had taken matters into their own hands and described sending out advocacy cards to Social Workers, GPs and primary health informing them that they could not turn unaccompanied minors away; *"…it's important for unaccompanied minors to know their rights".*

Some professionals were considerate of the number of unaccompanied minors they felt were accessing services, which they deemed to have a significant impact upon the resources available. The Consultant Psychiatrist felt it was something which needed *"getting on top of"*, as if this were a battle that needed dominating. They expressed how conscious they were of missing young people and how interventions needed implementing at a younger age. The Art

Therapist questioned inadequate funding of services and the impression that unaccompanied minors become a burden on these. Again, there appeared to be a link to value in the sense of who was worth having the money spent on.

Both Consultants felt services needed to join up, an interplay between physical and mental health, for example, with the possibility to share resources, as well as having support and backup. But there was apprehension of how this could work, if commissioners would listen, or if existing resources could accommodate such unity,

> *…we can't put our head in the sand, and we will have a bigger group than this, if the laws remain as they are, rather than moan about it we need to see who are those individuals and how can we then meet those needs.*
>
> *(Consultant Paediatrician)*

The reference to bodily senses in the professional's description was noteworthy once more, to give them a voice, for this to be heard, for them to be seen and to encourage others to look. The position of advocate was embraced here with determination to engage with and make a place for these young people in their own minds as well as in the minds of others.

Independence and connotations evoked vary from culture to culture, with age restrictions, milestones, expectations and permitted behaviours and responsibilities, such as driving and drinking alcohol, differing dramatically. Having this in mind and the complex responsibilities and experiences an unaccompanied minor may have had to contend with on their journey, their expectations of being looked after and cared for may contradict entirely those within Western society. Consequently, they battle against external systems in place trying to protect and organise them, as well as an internal system which has shifted and altered in response to their survival instincts. In a similar vein, the Art Therapist and Consultant Psychiatrist raised how many decisions were out of a young person's hands and made by others from a removed position,

> *It's government and companies that decide how money is spent that's wrong, not the people that are just trying to live their lives.*
>
> *(Art Therapist)*

> *The decision about this person's life is made by someone who doesn't really know this person, sitting in an office with a couple of others and how robust is this process. How*

*many vulnerable people are chucked out and how many not so appropriate people are kept in?*

*(Consultant Psychiatrist)*

When considering how much of what happens to these young people is out of their control, the question of whose responsibility are they arose. Professionals struggled to ascertain whether they should feel personally accountable or whether this laid elsewhere. The Art Therapist felt that they frequently had *"an alert out"* when in public, braced and ready to stand up for those being victimised or bad mouthed. However, instances such as this were witnessed infrequently, and mainly just in the media. They reflected on their capacity to invest and how they would get personally involved,

*A question I had before and still have is what can I usefully do and what am I prepared to do, because I also just want to live my cushy life and I'm not going to go out and campaign and bringing strangers into the house, so it's the tension really…It's more about do I want to or am I actually quite happy with the little bits that I do. Depending on the day I can feel quite selfish, and then other times I can think that's alright, I didn't create the problem, so I don't have a responsibility…*

*(Art Therapist)*

This extract illustrates the hopeless guilt triggered and the feelings of uselessness evoked in some professionals. As a result, an egotistic state ensues, and an unaccompanied minor is viewed as a stranger and outsider in an attempt to gain some distance from them. No blame or fault can then be attributed to the professional, thus they continue to live their happy and *"cushy life".* There is an oscillation between these positions of self-preservation and venturing outside of this innocuous standpoint, one activating the other when it becomes too overwhelming or perilous.

The Paediatric Mental Health Nurse also spoke of the conflict between the locality being welcoming, versus *"thoughts and voices around of 'not in my backyard'"* which illustrated a struggle of who should own 'the problem' and where should it reside. The Consultant Paediatrician mentioned the responsibility they felt they had to inform young people that *"England is not paved with gold"*. Although they appeared willing to engage with and take responsibility for tasks and forming relationships, they expressed the pain and guilt at not being able to do more, *"The thing that breaks my heart is I wish we could do more to help"*. This

predicament became too overwhelming for professionals to own alone and so the responsibility was attributed to society. There was mention of lack of resources and finances, with the Government being accused of not prioritising effectively and others needing to take responsibility. Comments were also made about foster care placements and the predicament of having no one to take in these young people. Yet again, this impression surfaced of the strain in demand to engage with this group of individuals, and the increased obligations when caring for and relating to them.

The next chapter presents a holistic view of the issues that ran between both parts of the analysis, pulling together the findings and literature review to observe if and how one complements the other and what, if any new information was highlighted which could be of use to external services and further research studies. Implications for practise and what I have learned will also be reviewed.

## Further Discussions and Conclusions

The previous chapter was divided into two parts to explore in detail the data that was collected and the themes present from each group of participants. Whilst there was an element of discussion within this, this chapter will take a more holistic view and explore the issues across both parts, whilst connecting it with literature previously reviewed.

There were various themes that were comparable within the conversations with professionals and discussions within the foster carer support group. The ones that specifically stood out to me were trauma, 'cold care' and 'unthinking racism', gaps in time, knowledge and understanding which spiked anxiety and impacted upon the cultivation of relationships, and language and communication. Some of my thoughts and observations have been gathered under these various headings to further reflect upon my aim which was to explore the challenges for the care network when providing therapeutic support to unaccompanied minors and how these were considered, worked with, and/or perhaps denied.

### Language and communication

It feels pertinent to begin by considering how this topic was talked about and the language used across the groups and interviews, as there were certain elements in common. Theory will be employed to unpick this further. During analysis of the interviews and group sessions, I noticed a prominent use of certain words and the struggle to find the 'right' expressions or terms; *"I'm not sure of the right way to say this"* (Paediatric Mental Health Nurse). There appeared to be a worry about getting it wrong, being offensive or politically incorrect. Although professionals appeared consciously aware of this, I was mindful of the unconscious systems at work also.

Foucault (1980 & 2019) describes discourse as organizations of thoughts comprised of opinions, ideas, actions, beliefs, and practices that methodically construct the subjects and the realms of which they speak. He argued that the expressions and words we utilise to construct these discourses derive knowledge. Discourse is inevitable since any use of language has an impact on an individual's perspectives, for example "freedom fighters" or "terrorists". Foucault believed that this knowledge comes from dominant social figures such as doctors, social workers, psychiatrists. Whoever possess knowledge and subsequent power and authority to determine 'conversations' about social issues. When power and discourse become connected in such a way there is a formidable element of control, as well as a strong influence over how issues are understood in 'reality'. For example, if the state controls the media, they ultimately control the 'truth'.

Words evoke meanings in our minds and are the currency of communication. This is also interesting when thinking about semantics; the study of words as signs and the different types of meaning that they also evoke. Some words have more than one meaning and we need to know the context in which the words are spoken to gain the correct meaning (Gill and Adams, 1992). This can be incredibly complex across varying cultures and adds to the barriers of communication found between professionals, foster carers, and unaccompanied minors.

Professionals were asked for their connotations and thoughts when unaccompanied minors were mentioned. It was not a surprise to hear many descriptive words used in response, such as,

- *"Resilience, tragic, brave, news"* (Art Therapist)
- *"Dedication, guilt, interesting life stories"* (Family Placement Social Worker)
- *"Extremist, risk, radicalised, vulnerability"* (Consultant Psychiatrist)

There were obvious direct links to unaccompanied minors in these examples, but I was also aware of the underlying associations to the professionals themselves. The risks that coincided with the work, the resilience and dedication required to stay engaged with these young people, the impact of outside influences such as the news, and the uncomfortable vulnerability that can result.

What was thought-provoking were the words used more than once by an individual or the same word used by multiple professionals. The Art Therapist referred to her work with unaccompanied minors as being *"quite interesting"*. Along with the Family Placement Social Worker's view of unaccompanied minors having *"interesting life stories",* I was struck by my use of the word 'interesting' within this study. A word commonly used to describe curiosity and intrigue, but its overuse making it appear lifeless and commonplace which is the exact opposite of what is trying to be communicated by its use. It is also a word sometimes utilised to hide behind instead of saying what is really felt and thought.

The word 'odd' and others used to describe uncomfortable difference were another example of this,

> *There is something odd about him' [the foster carer] says and his social skills are limited…She says he does odd things, quite sensory like he flicks her nose, she knows it's affectionate but it's a bit bizarre and socially it's not what we do.*
>
> *(Art Therapist)*

The preoccupation here was the young person not fitting in with social norms and the awkwardness of this. The oddness of their actions was misunderstood and confusing, meaning the young person themselves became labelled as odd. The Consultant Psychiatrist attempted to understand this 'oddness' by attaching it to cultural difference, *"…they are from another culture so are going to present as odd, by general perceptions of typical social behaviours and other things".*

The Consultant Paediatrician was thoughtful about how foster carers were trained and prepared for accommodating unaccompanied minors and highlighted the limitations of their training in encountering such cultural, behavioural and social differences, *"It's difficult for foster carers, the training doesn't accommodate it, they are working with a different breed as it were"*. Again, it was difference that was accentuated, but fascinating that the word used to capture this insinuates an animalistic quality and something not human. The Consultant Psychiatrist used similar terminology to describe extremism and how extremists were, *"outliers of atypical human thinking and human behaviour"*. They went on to question the feasibility of being able to really, *"track these people who are clearly alien…who develop an alien-like identity"*. The word 'alien' was also mentioned by the Paediatric Mental Health Nurse who was thoughtful about the alien environment these young people had to contend with. This also linked with the foster carers' concerns, fears, and comments about potential contamination, as well as behaviours and noises that deviated from the 'norm' and alien-like presentations and relationships.

It was noteworthy when considering unaccompanied minors and their varying faiths, the descriptive words used by the Consultant Paediatrician which had a religious association. They described a patient's experience as going *"through hell and back"* and when talking about their optimism for a cohesive service in the future for these young people to access, they said *"I hope and pray we can tie it all together"*. What was also striking during several of the foster carer group sessions was the use of religious language to exclaim disbelief, relief, or shock. Phrases such as *"Oh my god"* and *"Oh my good god"* were used by several of them when they felt taken advantage of, betrayed, or astonished when recognising an experience they had

previously struggled with alone, was actually a shared one. Although such expressions have become commonplace in Western society to describe such feelings, I was curious about what lay beneath the use of such language, especially when connected with young people who come from differing religious backgrounds and varying ethnicities. It is possible that these examples illustrate an unconscious motivation behind the words used when associated with certain subjects. For example, use of such phrases may have provided the professionals and foster carers with a means to hold onto their personal faiths which they identified with, when faced with those that they were less knowledgeable about. Or perhaps in these extracts, religion was being diminished in an unconscious attack on the young people who they felt at times invaded by.

Coinciding with this, it seemed there might be personal internal barriers provoked within participants by not knowing what to say, with worry of causing offence or misunderstanding. In turn responses become lifeless and primarily verbal, rather than noticing non-verbal cues, or being aware of how an individual may present. In a state of panic and uneasiness our replies can be heavily determined by our unconscious which draws upon the voices inside of us largely based on media, political bias, and our experiences, to try and understand a conversation which can lead to miscommunications and misunderstandings. In other words, our personal interests and attitudes will affect the vivid picture we have in our mind about what is said. Linking again with Foucault's ideas what we personally 'see' within a conversation will differ from person to person, as Gill and Adams (1992, p.96) describe, *"You may have a vivid picture in your mind of Mohamed getting off the boat, but without the precise meaning of the sentence what else you 'see' will depend on personal interests and attitudes".*

The use of language and misunderstandings was mentioned frequently by both professionals and foster carers. The Consultant Paediatrician highlighted, *"huge misunderstandings about any 'Ma', any migration, any immigrant, any migrant. Positive…maybe, but lots of negative".* They continued to explore how language is ever changing and how abbreviations can not only add to the confusion of what is being referenced, but acronyms can disregard individualism and uniqueness entirely. Consequently, a person becomes lost, *"…any acronym doesn't fit a person and that's what we have always got to remember, there's a person behind it"*. The Consultant Psychiatrist was also thoughtful about how interactions were heavily reliant on language. How, in many cases, poor communication results in a *"skewed understanding"* and

interpretations which are incorrect and do not meet the needs or expectations of unaccompanied young people.

When considering that many of these minors have fled their home countries due to war and/or political turbulence, it was striking how many words used in general description and conversation appeared to be associated with conflict, war and the journeys unaccompanied minors had taken. When considering the journey across vast amounts of water via boats, it was interesting to note the *"talks of floods"* (Art Therapist) in reference to the media, or how the numbers of unaccompanied minors *"goes in waves"* (Paediatric Mental Health Nurse). Bathroom floods mentioned by the foster carers were also poignant here. The word 'influx' was similarly used, especially when talking about statistics and the number of unaccompanied minors living in the local area, *"That's a huge influx"* (Paediatric Mental Health Nurse); *"...a significant influx"* (Consultant Psychiatrist). Other words connected to journey's worth noting were, *"shit, crisis, invasion, trafficking, extraordinary traumatic and horrendous".* As a result of these journeys, it was felt by many of the participants that these young people would likely become, "*quite rough and abrasive, abrupt or aggressive in response to people".* Allsopp (2017) and Allsopp & Chase (2019) comment on how the high levels of unaccompanied young men fleeing to Europe seeking refuge has provoked fears of a demographic disproportion and invoked connotations of virility and violence. This is perceived as threatening to the harmony of individuals within a state, as well as to the EU in its entirety.

War and conflict were present directly in discussions but also in the words used to discuss interactions with unaccompanied young people or about them. The Family Placement Social Worker spoke of "*family members being killed, scars and trauma"* whilst the Art Therapist considered how to defend these young people in the local community and the need to be *"prepared to have the argument when someone makes a foul comment about people trying to get what they want"*. The Consultant Paediatrician commented how the National Health Service was, "*fraught with potential issues"* and described getting the right treatment and what was needed as a *"minefield"*, a word to describe unforeseen dangers and hazards, but which also had strong connotations to war. In a similar vein FC6 used *"bomb shell"* to describe sudden feelings of shock and FC2 asserted the territory of her home with comments such as *"this is England"*.

The split between external and internal conflicts was another prominent matter and what got stirred and evoked internally by participants when certain words were mentioned. Whorf

(1956) highlights how the structure of our language determines how we perceive the world and the people about us (p.96). Could it be then, that the unconscious use of words in this way was an attempt to make a connection with these young people and for there to be an aspect of shared understanding? On the other hand, Sontag (1991) explores the use of metaphors (*"...giving a thing a name that belongs to something else"*) in relation to illness, highlighting how we are often unable to think without metaphors, but this does not mean that we should not abstain from or try to retire from using such interpretations (p.91). Sontag emphasises how modern medical thinking has been interlaced with gross military metaphors, *"Disease is seen as an invasion of alien organisms, to which the body responds by its own military operations, such as the mobilizing of immunological 'defenses', and medicine is 'aggressive', as in the language of most chemotherapies"* (p.95). She accentuates that such metaphors contribute to the stigmatizing of certain illnesses and by extension, of those who are ill. In the same way, the afore mentioned words and examples seemed commonplace in the participant's attachments to unaccompanied minors (their identities and their journeys for example). These *"metaphoric trappings"* thus distort and inhibit interactions and connections with these young people, by making others irrationally fearful (pp.99-100).

**Trauma, 'cold care' and 'unthinking racism'**

It is well researched and documented that looked after children are highly likely to experience severe trauma, neglect and abuse and several important theories highlight the various levels of deprivation they also must contend with. Due to the findings of this study, it seems important to review and explore how these multiple layers of deprivation can also impact upon the life of an unaccompanied minor, how they are responded to and also viewed by their networks.

Henry (1974) coined the term 'doubly deprived' to describe how a looked after child is not only impacted by the deprivation caused by their external circumstances (also known as primary deprivation), but through the different defences they may deprive their internal self of (secondary deprivation). A young person may reject or deny experiences of linking and connecting with others both internally as well as externally, for example, by dismissing the support offered by therapists or foster carers. Following on from this Sutton (1991) carefully considered his work with abused and severely deprived children in terms of both general management and psychotherapeutic treatment, and emphasised how,

> *... all the children, at times, some in more subtle ways than others, made their therapists feel useless, helpless, rejected, abandoned, messed up or cruelly treated - precisely the*

*experiences and feelings which the patients themselves found intolerable or hard to bear* (p.1).

It is incredibly important for the therapist to avoid a re-enactment of the child's experiences thus contributing to a persistent cycle of deprivation and becoming unavailable to the child. Developing this further using a case example, it is illustrated how a severely deprived child could end up within a deprived clinical setting which could reproduce the depriving environment of the child further by denying resources to children's services in favour of those for adults, for example. It was felt that this process occurred specifically because of countertransference demands but with an additional force of institutional processes. This phenomenon was termed 'triple deprivation'.

Emanuel (2006) took these concepts further by exploring the impact of triple deprivation upon traumatised children when working as a child psychotherapist in a looked after children's social care team. She describes her empathy for social workers who were often in unstable and stretched teams and subjected to painful and powerful projections. For a traumatised child who has no way of voicing their terror, it is likely to be projected out into others (those in the networks surrounding them for example) in the hope that someone will understand their emotional state by having to experience the feelings themselves. However, with no space or time for this to be sensitively thought about, or with inadequate management support for example, the foster carer or professional who are now the bearer of these intense emotions may need to either discard them elsewhere to free themselves of the unpleasant burden or defend themselves against the invasion of such unpleasantries. Thus, the deprivation enters the care system impacting the staff throughout the organisation and how a young person is supported, or not. Britton (2005) reinforces this with thoughts of how unconscious processes influence professionals' responses and the intensity (or lack of it) provoked in a case. He suggested that *"severely deprived children are in contact with professionals and carers who re-act to them in a way that repeats the child's own unspoken dynamics within his own family"*.

Quick moves from one placement to another and the management of these were considered by both professionals and foster carers, as well as the impact upon a young person. There seemed to be a link here to Britton's (2005) thoughts of how the unspoken dynamics of a young person's deprivation and neglect from the past could become replayed within a foster family or professional network. For example, an abrupt move from an unaccompanied minor's family life and home which may have been out of their control or without their say, then becomes

replayed within poorly planned moves between foster care homes. Emanuel's (2006) continued thoughts on this triple deprivation made me think about the intensity of confusion and anxiety which can cloud a network from being able to think more rationally and connect psychologically to what is occurring. Thus, there is little space and time given to really considering and preparing a placement move nor the emotional needs interwoven with this.

Menzies Lyth (1988) comments further about the experience of working with anxiety and how this can impact upon the functioning of not only the individual professional, but an organisation holistically. Exploring the functioning of social systems within nursing staff of a general hospital, she emphasised the high levels of tension, distress, and anxiety amongst the nurses, and understanding the reasons for the level of intensity was considered integral. The primary task of the nurses was to provide continuous care, day, and night, to ill people who could not be taken care of in their own homes. The intimate physical contact and work situation aroused strong and mixed feelings in the nurses of pity, compassion, love, hate, resentment, and envy (p.46). It was noted that this was intensified by dealing with psychological distress in others, including colleagues, the resentment and envy that hospitalisation can evoke in some patients, as well as mixed feelings about inadequacy and dependence, and complicated feelings of their relatives also, all of which appeared to increase the experience of stress on the nurses (p.48).

Consequently, there is a need for the members within such an organisation for social and psychological satisfaction and support in the task of dealing with anxiety. The use of the organisation in the battle against anxiety, *"leads to the development of socially structured defence mechanisms"*.

> *An important aspect of such socially structured defence mechanisms is an attempt by individuals to externalise and give substance in objective reality to their characteristic psychic defence mechanisms…The socially structured defence mechanisms then tend to become an aspect of external reality with which old and new members of the institution must come to terms with* (pp.50-51).

These defences take the form of splitting, depersonalisation, categorisation, detachment and denial, ritual task performance, redistribution of responsibility and irresponsibility, delegation to supervisors, idealisation, and avoidance of change, all of which help the individual with the evasion of anxiety and avoid an experience of guilt, uncertainty, and doubt. Menzies Lyth (1988) draws upon the work of Bion (1962), Klein (1975), and Jacques (1955) (p.78) when highlighting the importance of understanding the functioning of a social institution that

performs in this way and the employment of diagnostic and therapeutic tools to facilitate social change.

When aligning this with the data collected in this research study, foster carers care day and night for young people who cannot be taken care of in their own homes by their biological families. Similarly, the data shows the complex interplay of the arousal of intense and mixed feelings from both foster carers and unaccompanied minors, including resentment, envy, inadequacy, and dependency, as well as dealing with psychological distress. This accentuates stress and anxiety levels within the foster carers and the need to externalise this onto the outside organisation of social care as a means of gaining support and avoidance of guilt, uncertainty, and doubt. Further understanding of this expulsion is required by those within the network so unconscious patterns of a young person's past do not become replayed by the organisation, prohibiting triple deprivation from becoming enacted within the organisation.

Within the findings from the foster carer group more profoundly, it was recognised that the trauma manifested and emitted within interactions and relationships with unaccompanied minors was different from that of looked after children. This raises the question of how the experience of such trauma may also obscure interactions within a network and add another layer of complexity to the anxiety previously suggested. An example of this was present in the section *Ability and Availability to care* where foster carers shared several concerns regarding the damage and reprisals of making a connection with a traumatised young person and how they presented. There were concerns that sharing an experience could enliven something uncontrollable in their relationship, that they could be emotionally taken advantage of or overloaded, and lastly that they would become 'cold carers' and numb which could impact not only their current relationships but future ones too. Comparably in the section *Working with the Unknown* the Art Therapist gave a detailed narrative of unaccompanied minors arriving in a freezer truck and how by numbering each individual meant their vital health needs could not be separated when critical care and support arrived. The hopelessness, risk, and trauma apparent in this scenario seemed to 'freeze' and paralyse the thinking of the professionals' present, their ability to connect with what was happening in front of them, as well as the state of each unaccompanied minor as separate human individuals.

In both examples, as well as others in the findings chapter, defence mechanisms were employed as if to prepare and arm oneself for or against the impending revival of trauma that felt rife and potentially deadly. As I reflected on the foster carer group sessions prior to and during analysis,

I was reminded of how difficult it sometimes was to think during these sessions, as well as when faced with them again via the raw data and material I had to analyse. At these times, the design of this study to incorporate a second mind via a Co-facilitator seemed an imperative one, so at least one mind could continue to assist thinking if the other had become shut down or overloaded. I was also mindful of the need in me as a researcher to distance myself from the data analysis process which became overwhelming at times as I had to relisten to the conversations about trauma and its impact upon the young people themselves, as well as within relationships in the network. I felt that on behalf of the group I continued to process this for many months afterwards and it was much later before I could begin to consider perhaps the secondary traumatic stress this group could have exposed me and the Co-facilitator to. Konistan's (2017) thoughts on this subject and the other ways this could be understood (vicarious trauma, counter transference, compassion fatigue and burn out) was helpful when trying to understand this and put it into perspective. There were painful limitations of what I could do as a researcher and a psychotherapist to avoid becoming a 'cold individual', too overwhelmed by the data. Bion's (1959) theory of the three emotional impulses within relationships and the failure of the 'Alpha Function' when stirred by intense anxiety, instigating the accumulation of 'Beta Elements' (unprocessed emotions, thoughts and experiences), helpfully contributes to the understanding of my need to disconnect and my periodic stifled rationale.

Another layer of complexity evident within interactions with unaccompanied minors was institutional racism which appeared to make it much harder to connect with 'the individual' and see their separate needs when professionals and foster carers were *"flooded"* and overwhelmed by the trauma present. It was not just an individual's skin colour that was mentioned, the unconscious bias from the media or the unthinking racism named by the Art Therapist, but the organisational racism declared by the foster carers. Their comments about unaccompanied minors being treated as second class citizens without the same importance as an *"English lad"* accentuated this. Examples of unconscious racism also manifested in the language previously described, as well as the professional contradictions which run throughout this thesis such as the welcoming nature versus the *"not in my backyard"* attitude. There was a question of who owns the racism, the individual or the organisation, or whether it is that easy to define. The conflict of who owns this problem was present in comments about England not being *"paved with gold"* versus it breaking the heart of professionals when they felt unable to do more. This appeared to provoke guilt which became externalised by both professionals and

foster carers alike, as a societal issue with the professionals regarding it as a funding and Governmental plight, and foster carers seeing it situated more directly with social workers and their lack of time and understanding.

There seemed to be a dichotomy between a deep-rooted hatred and a resistance to supporting those needing help, whilst functioning in the role of a helping profession and being overwhelmed by what was asked of them. The suggestion of unaccompanied minors blending in and becoming unnoticed was suggested as advantageous which demonstrated how difficult it was for the professionals to maintain an unbiased stance with the threat and risks provoked by difference. It emerged that it was harder to identify value and worth within the 'other', with the question of whether 'this group of individuals' was worth having monies spent on them, which ultimately restricted closeness and relatedness free from potential threat. Manipulation and exploitation were expectant fears mentioned by both professionals and foster carers, and there was a need to protect oneself with safeguarding measures. There was also a struggle to *"like them"* and an increased strain to engage with the obligation to care. It was notable that pathologies, labels, and diagnosis from services and emphasized by foster carers brought distance to the trauma, but also attached something familiar to an individual's presentation which made it 'less different' and intimidating.

These additional factors (working with trauma and the unconscious institutional racism) add another layer of complexity which could be called 'Quadruple Deprivation'. The deprivation extending much wider outside of the organisation, perpetuating into and being impacted by a social and political context too. With the notion that the manifestation of trauma is different between indigenous young people and unaccompanied minors, it could be argued that unaccompanied young people are a distinct group which entice a different response from those around them. This combined with political drivers, media influences and societal views add to this complex layer of Quadruple Deprivation, with a young person already having a set of pre-existing biased assumptions thrust upon them which will be unconsciously enacted or held by a professional and/or foster carer depending on their political associations locally and nationally, and where they position themselves in society. This is likely to feed into a care network impacting upon the challenges of providing therapeutic support to an unaccompanied minor, heightening the defences employed when working with and interacting with them. When considering the population of the locality and the underlying sense that some areas of the country felt they were disproportionately looking after more unaccompanied minors than others, you can see how the political and societal stance further complicates and may prevent

important connections with these young people from being made. In addition to the capacity to think separately from this and see an individual's needs.

This coincides with Glenn's (2002, p.183) thoughts that unless a therapist examines the families that they work with more closely, as well as the wider contexts that impinge on these families, they are likely to adopt various stereotyped versions that exist in societal discourses about refugees,

> *A dilemma for practitioners is "how to establish and maintain a sensitive balance between clinical and political dimensions in this work" and the losses and gains of maintaining neutrality when working with refugees. Moreover, "unless therapists appreciate the importance of their own systemic connection with the wider political issues, they are likely to slip into unexpected blind alleys" (Papadopoulos, 1999, p. 118).*

**Gaps in time, knowledge and understanding**

Both groups described or insinuated spikes in their anxiety levels when in positions of 'not knowing'. To clarify, this is to not know facts about something or it being different from the 'norm' which makes it much harder to connect and empathise with. One way that both professionals and foster carers appeared to manage this was to attempt to think from an unaccompanied minor's position, and figuratively wear their shoes. For the Art Therapist, putting themself into the position of an accompanied minor was their way of trying to gain some common ground and a different perspective. Alternatively, other professionals did this from a removed position, considering what it was like from the position of a foster carer and the challenges they faced, rather than commenting on their own challenges. The young people also appeared curious of what it was like to be in the position of another, with one foster carer commenting on items of her clothing and shoes being borrowed by the unaccompanied minor in her care. However, she was unable to be curious about this and what it perhaps symbolised for the young person, and it was considered an invasion into her personal space and rude.

In trying to deal with and understand these unknown elements that both professionals and foster carers were faced with, words such as 'alien', essentially meaning unknown and unidentifiable, and 'odd', suggesting the opposite to the norm and different, were exercised. There was an acknowledgement that gaps in knowledge could be filled with internal belief systems as well as the influences of external resources, such as the media and societal and relational views. Religion and faith also fell under this umbrella with both sets of participants lacking in

understanding. This was uncomfortable for both professionals and foster carers alike who wanted to perhaps know more but also wanted to hold onto their own faith and religious identity which ultimately upheld the distance within their relationships. This allowed for threats of vulnerability and risk to grow within these gaps and a fine line appeared between who was the most insecure, the young person, the foster carer or the professional.

In parallel with unaccompanied minors, foster carers and professionals expressed how at times they felt not heard, forgotten and over shadowed. Foster carers felt they were made to feel this way by professionals as well as the young people themselves who might go over their heads to a social worker or health professional. Professionals felt they missed out on projects and were unable to interject their expertise. Similar feelings were evoked in me during recruitment when meetings were overshadowed by other professional duties deemed more important, and when my study was forgotten by the educational department of the Trust after a prospective participant quizzed them about it. All these examples provoke an invisible, unimportant, and undervalued status. Unaccompanied minors themselves were often cast into such positions by their networks, with the expectation that they could be available at a moment's notice to attend appointments or are left waiting in anticipation of further communication as if they have nothing else to do. I felt that Sirriyeh's (2013a & 2013b) study about relationships and constellations within foster placements from the accounts of foster carers and unaccompanied minors was of relevance here, specifically the model of 'lodger'. This is where relationships between young people and foster carers are distant and have a degree of tension with the foster carer feeling they are only able to deliver the service they 'are contracted to provide' and consequently a young person does not have a sense of belonging. Such feelings were reinforced by FC1 who expressed their home was more like a hostel than a home. On the other hand, the expression of love and acceptance was also mentioned and connected with by FC3 which associated with the 'like-family' model, *"I see him as my son"*.

Time was another theme that both professionals and foster carers commented on extensively. There seemed to be the need to remove oneself from certain interactions to gain some time, distance, and perspective to digest what they were faced with. For others they valued the time they had in appointments which offered a different pace and space for thought, due to communication complexities and translation, compared to appointments with indigenous young people. This contradiction of how to manage needs and provision within the metaphor of time became paradoxical; there being a welcomed amount of time to think within appointments versus not enough time to do anything properly. Additionally, time was referred

to quite explicitly when foster carers spoke of a young person's 'leave to remain' status, whether they were still wating for confirmation, given a year, or granted an indefinite stay.

The pressures of time were apparent within the foster carer group sessions also, as some were unable to attend certain weeks due to clashes in appointments for their young people. Professionals expressed the limited time in their appointments and what they felt they then missed or perhaps were unable to provide a young person with, as if short-changing them. This limited time also had an impact upon me as a researcher as it made the recruitment of certain professionals a challenge. Across all examples there appeared to be a sense of guilt evoked. As a researcher I felt I was being intrusive by requesting a short amount of their time and worked hard to be as flexible and as available as possible. Foster carers questioned what more they could give, if what they were doing was correct or enough, whilst professionals spoke about offering open ended reviews so contact could be continued and not severed. The Quadruple Deprivation of trauma may increase the pressure of time, resulting in there not being enough of it to get to grips with what a young person brings or presents with, or equally the need to actively avoid the parameters of time to gain a safe distance from this.

With this new idea of 'Quadruple Deprivation' in mind, the guilt provoked may link to something more unconscious which is embedded socially and politically, encouraging time constraints and limitations. For the foster carer and professionals this might trigger an internal struggle as they wish at some level to engage and feel as if they want to give more. However, the guidelines within which they work, and which dictate treatments on offer and their duration, result in restrictions which are out of their control. The work of Garland (2002) and Youell (2019) helpfully encourage us to hold in mind how timings need not be restrictive, even within these parameters. They suggest that getting the timing right for the individual is crucial when regarding interventions and offering therapeutic spaces acknowledging that this is complex and not straightforward. They remind us that an individual should be seen with their own responses to trauma with time spent on getting to know their personal qualities and experiences, and not as a member of a *"uniform population"*. In addition, boundaries of time may feel and mean something quite different to an unaccompanied minor compared to the professional, for example, as culturally a young person may not have had experiences of engagement with mental health or paediatric services before coming to the UK, and an understanding of all that this entails. This also impacts upon timing and whether things are given too prematurely for that individual or denied by them entirely.

## Concluding thoughts

This final section directly addresses the research question and what answers this investigation provided. The specific methods of data analysis applied will be contemplated, followed by comments on my research journey, future potential areas of study and lastly recommendations.

### What answers were discovered?

This study matured from my curiosity of the impact working with unaccompanied minors and the support networks around them and how their needs were attended to. The main question, "*Exploring the challenges for the care network of providing therapeutic support for unaccompanied Asylum-Seeking Minors"* grew from the assumption that there was an avoidance of or difficulty in directly engaging with what a young person brought into an interaction with those around them who there were to offer support, guidance, and a nurturing and/or therapeutic environment. This was built upon direct observations I had witnessed in the CAMHS clinic where I worked. The overarching objective was exploratory in nature and to search for meaning.

This study illuminated that one of the greatest primary challenges for the care network was getting in touch with the individual needs of an unaccompanied minor, especially when there are multiple levels of deprivation within the systems around them and the complexities of trauma interwoven amongst these. An additional challenge was staying with and being curious about these expressed needs, and whether they could be contained and met by professionals and /or foster carers. My initial observations from a service perspective signified that enacted behaviours were 'proportionate' and 'in-accordance' with what these young people had experienced and witnessed. This dulled down the possible meanings behind the behaviours observed and lacked a therapeutic stance. Looking from two different perspectives, this research encouraged professionals and foster carers to take time out of their daily routines to stop and think, in a space free from judgement and criticism, to explore and digest their experiences of working with and supporting unaccompanied minors. It was striking how little time had been previously provided in this format for both sets of participants, but also how hard it was to request, orchestrate and participate in.

Accounts of successes and challenges were painted from both roles, with notable similarities and parallels of themes across both the interviews and support groups. Foster carers exclaimed their gratitude for the freedom of a non-judgemental space to think about the work they did, their experiences of being foster carers and the relationships they had formed with the young

people they supported. Although maybe not as explicitly, professionals seemed to find the time to reflect on what was stirred for them relating to this topic of interest and helpful. Akin to Mawson (2019) I feel this study demonstrated,

> *…how important it is for staff involved in painful and stressful work to be given space to think about the anxieties stirred up by the work and the effects of these anxieties on them. The cost of not having this is considerable, both to clients and to workers. As well as offering much needed support, consultation can offer the opportunity for insight and change in the group and wider institution, if the pains and difficulties can be tolerated* (p.87).

This research also highlighted a difference in caring for an unaccompanied minor compared to an indigenous looked after child. Unaccompanied young people under the age of eighteen are classified as 'looked after children' upon entering the UK and it is commonplace and assumed by many local authorities and services that they come with the same kinds of issues, difficulties, and complexities as an indigenous young person. This ultimate refusal to look at and consider the apparent differences fails to see the individual and their needs, thus leaving all parties (professionals, young people, and foster carers) at a loss and unprepared. This study concluded that there were implicit differences, and it was incongruous to expect professionals and foster carers to support and work with unaccompanied minors and to do so proficiently, when they are lacking sufficient training and have unrealistic expectations of practice, policies and strategies thrust upon them. Stark differences included religious beliefs, cultural implications, expectations of what a 'home' is, and how this shapes internal belief systems. For example, although there were observations and attempts by FC2 to find familiarities in the Christian faith when compared to the faith of the young people she accommodated, interpretations of these were varied. 'Love thy neighbour' was more figurative for FC2 and much more concrete for the young person who wanted to make real connections with the people that lived next door. Miscommunications and misunderstandings grew from this, much like it did from other important religious celebrations such as Ramadan. This was unfamiliar territory to the foster carers who were given little external support to understand a young person's needs during this period. From this, anxiety and fear grew, and curiosity and learning were limited. A final example was vaccinations and personal histories and how these differed greatly between unaccompanied minors and looked after children. Both professionals and foster carers highlighted how the lack of information an unaccompanied young person comes into care with

escalates concerns of risk. This was revealed in conversation about TB as well as other possible contagions that could be damaging to those around a young person.

Types of trauma, how these are experienced, internalized and the impact upon the individual and those around them was another aspect. Distinctions between adverse childhoods experiences and environmental trauma and loss were predominantly discussed. The term "*Trauma Monster"* was also born within the support group to describe a multitude of facets, such as greed, emotional burden, fear, and the need to defend against something that could be quite frightening, shocking, and contagious.

Unaccompanied minors were identified as a disadvantaged group with less advocates, but there was a desire in many of the foster carers and professionals for this to change. Unfortunately, there was a paralysis in many of not knowing how to make this change along with being ignorant of where to go for support. Consequently, this 'not knowing' position led to two distinct stances, becoming a *Detective Mother* who had to make guesses to seek clarity and understanding with the awareness that they might not achieve the insight they desired, or refuse and deny difference and individualism completely. These standpoints were influenced by assumptions (of trauma experienced, faith groups and previous experiences of home life, for example) which were cultivated by national statistics, views, and opinions within the locality where one resided and medical influences, to name a few. It was uncomfortable for many to be uninformed and out of touch which resulted in a pressure to control and enforce boundaries. The expectation of a young person was *"You either deport or adapt"*, which was highlighted by the Co-facilitator in the support group.

Connectivity with the fear and anxiety cast from the lack of clarity stimulated concern of damage that could be caused and vigilance about reprisals of making a connection with an unaccompanied minor. This was considered in three central ways by foster carers, *sharing an experience* and what could be absorbed, internalised, and enlivened within such a relationship, becoming *emotionally disconnected* and needing to protect oneself from being taken advantage of emotionally or being over-loaded with unpleasantness, and lastly becoming a *cold carer* who switches off all emotions and dissociates, possibly resulting in not being able to enliven future connections with others. Thus, this impacted upon the availability and ability to be able to provide therapeutic support and engagement.

This study has brought to attention that assumptions moulded by external sources contribute to the formation of one's internal core belief systems. The enlivened *Trauma Monster* and

concern for connectivity, and its longer-term impact upon relationships, where all challenges faced by the care network. As a result, creative responses, curious thinking, and reflectivity were diminished, and unconscious hatred and institutional racism became perpetuated. 'Quadruple Deprivation' was coined to identify the additional layer of complexity and deprivation unaccompanied minors and their networks face which extends to the wider social and political contexts. A combination of political drivers, media influences and societal opinions form pre-existing biased assumptions and unconscious re-enactments that cast these young people into already formed stereotypes and expectations. Consequently, these obstruct them from accessing resources and those in their care networks from relating and being able to engage with them on a more authentic level. This builds upon the theories of Henry (1974) and Emanual (2006).

## Methodology and Analysis

This study used thematic analysis to explore and develop themes from interview and support group transcripts. When considering the process of this analysis, the Art Therapist's comment regarding unthinking racism and the necessity to categorise others stayed with me. I began to think about how, in a similar way but with more thought, my use of thematic analysis continued in the same vein of categorisation. My task was to try and organise and make sense of the gathered material, but also a process of sifting through and drawing attention to specific topics and thoughts, whilst being mindful of areas that were left out. This was mainly due to limits of time and space within this thesis, with the areas excluded incorporating identity formation, grief, embarrassment and weaknesses, hierarchy, and morals and values.

During analysis, my attention was drawn towards professionals' views of whether these young people wanted to be engaged with or seen at all. I felt that this connected with my research, and the interviewees themselves. They had been given the opportunity to think about this topic with the knowledge that their answers and thoughts would be looked at in great depth and detail which may have felt like an exposing and vulnerable position to be in. Alternatively, it may have felt like a helpful space, with another mind to allow extra room for exploration and thought. My research journey had several occasions where I had felt overloaded and deflated by the amount of data to comb through and connect with. There were times I wanted and needed to distance myself from it, as well as to separate it into much smaller fragments, themes, and sub themes albeit at times an excruciating experience. Like an accordion, I moved back and forth between intimacy and distance with the data. With hindsight the quality of data and

material available could have been explored over two theses which understandably made the task of analysis, the documentation of findings and overall conclusions difficult.

An additional compounding issue was my positions as researcher and practitioner, which echoed the personal and professional conundrum within the data. My time with the foster carers was very emotive where I engaged directly with the way they managed the trauma expressed by the young people that lived with them. I experienced it first-hand physically and psychically and this aided in identifying with foster carers. At the same time, I also had to stand back and analyse the data my research had produced. Thus, it was integral to have 'another mind' present in the Co-facilitator not just within the support group itself, but via a consultation space, external support, and debriefing. As a result of these two positions, this research study offers a unique perspective of binocular vision which little research to date has explored in such a way, meaning the process has been incredibly rewarding, enlightening, and one that I am incredibly proud of. Perhaps little qualitative research has been completed in this way due to the difficulty of listening to and being in touch with trauma.

Having a psychoanalytic perspective when constructing the research design, collecting the data and through analysis I felt brought a distinctive element to the overall study. Being considerate of both group's unconscious responses and communications was something that solely being in a researcher's position would have been more difficult to gain or be in touch with. With this informed thinking and freedom of free associative conversation it meant intricate topics could be spoken about and explored, as well as looking at how this emotionally impacted upon foster carers and professionals. This deeper layer of thinking and responding appeared to hold the foster carer group in a way which enabled them to gradually be honest about their thoughts and observations, and thus provided them with containment. They were also able to leave certain subjects and feelings behind in the room after the session with the Co-facilitator and myself, to continue digesting and hold on their behalf until the following meeting. Having two facilitators provided the ability to consider the powerful and full session material and on various occasions become the thinking function for the group when it was uncomfortable and "*flooded"*. It allowed for one of us to dissociate and become lost in the material whilst the other remained engaged with an ability to contain, a position that often oscillated between us. In this way I feel that the research design met the aims of the study's objectives. The emotional labour of being a researcher was painful but the use of countertransference with both sets of participants was an incredibly useful and informative tool. The use of my professional skills of managing the exposure of emotionally challenging work via listening and being cast into a position of

experiencing relived accounts, was of value when communicating with both professionals and foster carers.

Future studies and Recommendations

There remains so much more to explore in this area, and it is one which is constantly changing, with many areas to research further. As highlighted in the methodology, in a few years between data collection and writing up the findings, the political stance in the UK has shifted. From an initial focus on immigration and defending boarders being the driving force of Brexit, to an identified need for change and evident racial inequality being emphasised by the Black Lives Matter movement. This is of importance to bear in mind when exploring such an emotive and politically charged subject.

Future studies in this area could incorporate a male foster carer perspective as well as input from unaccompanied minors within placement with these specific families. Both voices were missing and as most unaccompanied minors in the locality were male, a stronger male perspective and observations may have brought up different themes or opposing thoughts to those spoken about by the female foster carers and professionals. More consistent involvement from foster carers and protection of their time to attend the support groups may have changed the dynamics and direction of conversation, and then the material I had to analyse.

This study has highlighted that professional teams and foster carers need substantial preparation for what they might be faced with when supporting an unaccompanied minor. Adequate training from those who have had previous experience and insight, and a space to widen thinking and open and develop curiosity should be mandatory. This will prevent blind sightedness by fear and anxiety of the 'unknowns' of external realities and those internally which can be deeper rooted and unconscious. I would recommend that more time is given to encouraging and supporting care networks to connect with their unconscious biases and how these impact upon their working relationships within an organisation as well as with those that engage with it. If this is not encouraged, it is likely to be evaded. Moylan (2019) highlights the importance of knowing and being aware of the ways an institution can, *"become 'infected' by the difficulties and defenses of their particular client group"* (p.27). By supporting a thinking space, free from judgement and critique, feelings can be utilized to consciously challenge problems in a fitting and straightforward way, rather than succumbing to avoidance and despair.

Both the professionals and foster carers were left without any ongoing support, with no work discussion space to encourage reflectivity. The data tells us that for foster carers, there is no space to consider before receiving a new placement and none after they move on. Consequently, they are left with material which remains undigested with no time given to processing one experience before the next. Fragments of this previous relationship and experience are likely to be relived within the new relationship with the young person in placement. Both professionals' and foster carers' concerns about 'saying the right thing' and 'causing offence' stifled their curiosity and ability to learn from their experiences and interactions with unaccompanied young people. It is evident that more needs to be offered to support those who work directly with these minors, not just strategically but psychologically. By 'doing' it prevents thinking and the body and mind connection, thus the cycles of numerous layers of deprivation perpetuate and penetrate the care network, distorting what can be contained and offered. The cultivation of such a space would also allow for positive accounts and stories to be shared and enlivened, thus ushering feelings of love, acceptance, and shared understanding, consequently stimulating curiosity and a healthy desire to understand.

Emanuel (2006) advocates for a space to understand the meaning of communications, as well as acknowledging the power of projections. Carers cannot be expected to remain thoughtful and receptive when under a continuous barrage of such disturbing projections. She found that by offering consultation it provided a forum for discussion to facilitate communication between agencies, where conflicts, rivalries and splitting entered networks, to understand where and how these obstacles within communication arose, also, ensuring there is a space for clear thinking and planning for the needs of the young people at the centre of the work. Focusing on just the child can leave the foster carers and social workers, for example, feeling neglected and misunderstood. This can then impinge on the care and attention they feel able to commit to a young person.

On multiple occasions how the bodily senses were spoken about and used to describe interactions with unaccompanied minors, was noteworthy across both sets of data. These had positive and negative connotations. For example, foster carers discussed bathroom habits and behaviours, and the exposure to what they had to smell, hear as well as feel which elevated fear of contamination. Professionals spoke of burying heads in the sand and how screens and paperwork got in the way of really seeing the individual. These references to the senses made me think about how trauma impacts the body and is held within it. Consequently, how this impacts the individual who has experienced the trauma first-hand, as well as those around them.

Research into trauma and its influence neurologically and physically has increased tremendously this past decade, with key texts from Porges (2011), Van de Kolt (2014) and Music (2019) changing the way in which we understand these links. Further exploration into this area regarding unaccompanied minors and their care networks would be beneficial to further understanding the obstacles care networks face.

These care networks also need to be supported to position the societal and political contexts at the centre of their work and recognise that discrimination and oppression is a likely reality when working with unaccompanied young people. They need to be provided with an opportunity to bring the unconscious bias and racism to the fore of their thinking in a safe environment to explore how this permeates into the work and relationships they have with these young people. We cannot "know" what the individual experience of anyone else is and so they should be helped to adopt a "not-knowing" position and encouraged to be curious about the narratives of others, much like the foster carer support group in this study was able to begin to cultivate (Glenn, 2002, p.187). If we do not engage in conversations about differences (culture and race for example), the unconscious biases and internal racism we possess, or as Bion (1959) would describe it (H), will intrude upon professional capabilities for thought, engagement and support we provide to young people in need. The question for organisations to then consider is, how are we able to think about the (H) in all of us?

My research has provided evidence which supports Keval's (2015) thoughts that,

> *professionals face pressures both from within and outside their organisations to create certainties in their work which may not always be possible. It is sometimes expressed in a culture of prescriptive thinking or a manual for thinking in place of discovery that can run into the danger of recreating a psychic retreat of sorts by avoiding the inevitable pain (and joy) of learning from experience and genuinely labouring over ideas…As professionals grappling with issues of ethnicity and race there is often a temptation to take a purely intellectual approach to the subject matter and draining it of any feeling so it becomes sanitised and 'safe' to work with…The danger is to mimic the very simplicity and lack of depth or dimensionality that forms the very fabric of racist thinking* (p.41).

It is also important to contemplate the political trauma from both sides of a relationship when working with unaccompanied young people, in terms of what is getting projected and evoked within the dynamics of the relationship and within them as individuals. Maybe Bion's and

Kavel's theories can be employed here again when trying to explain what cannot be tolerated within institutions and the institutional racism that exists. Individual professionals and foster carers are a part of and form larger organisations, such as the NHS and Social Care systems. They often do not have the time nor invited to a space where they can explore their internal racism and (H), thus it becomes perpetuated within the system/organisation. How can they then be expected to offer housing (in external reality and internally psychologically), where these young people can feel accepted and understood, if it is the norm to attack thinking and dull down curiosity? Further exploration into colonialism and its historical context (including generational trauma), and its impact upon mind and body, and internal object relations (Lowe, 2008 & 2014), may also benefit care networks.

I hope that these findings and recommendations can be shared with the Trust in which the research was conducted within and others, as well as be communicated to wider audiences via conferences and team events to stimulate further curiosity and conversation about this area.

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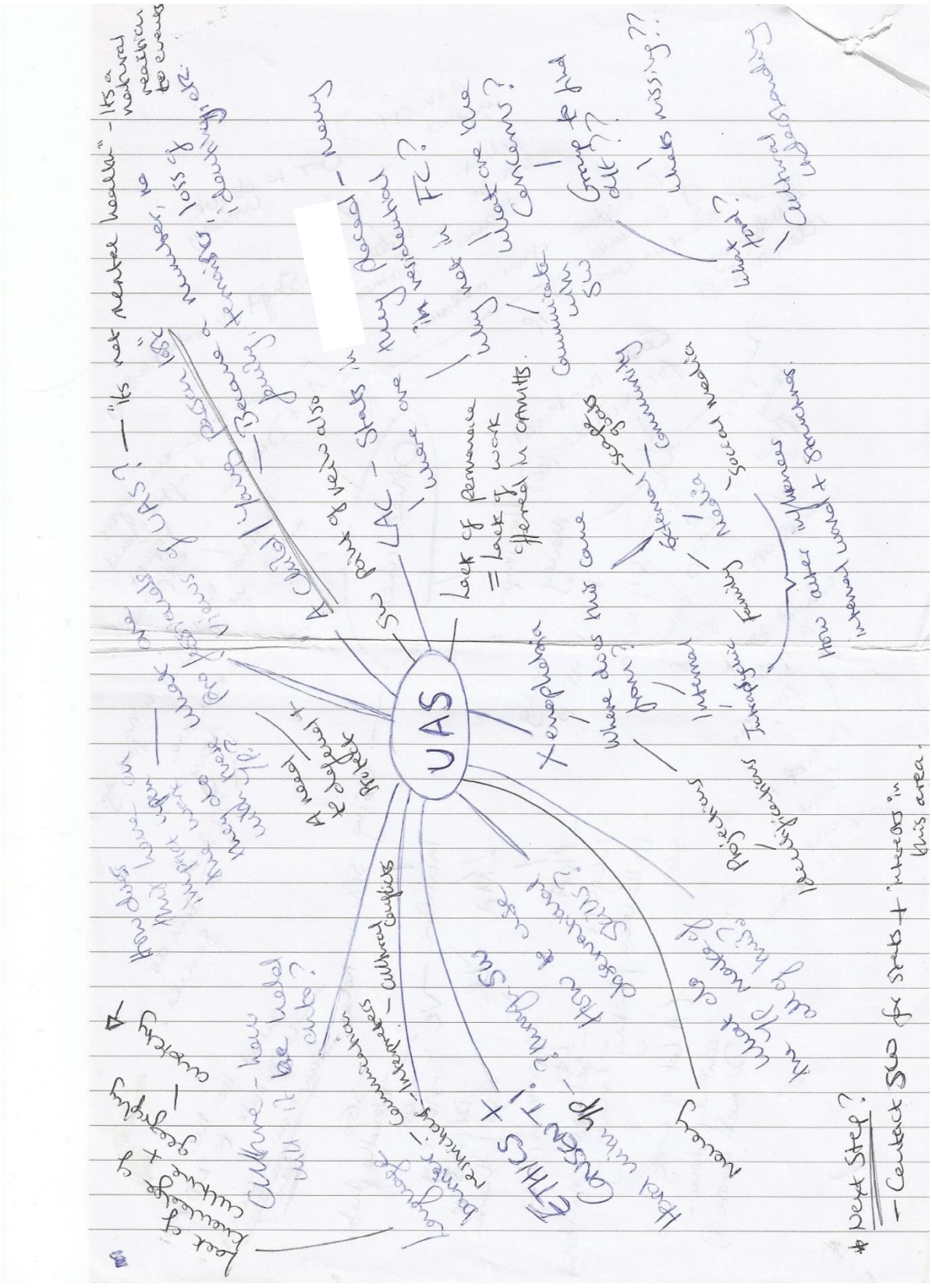
# Appendices

I. Initial brainstorm
II. Interview questions
III. Participant information sheet (for professionals and foster carers)
IV. Participant consent form (for professionals and foster carers)
V. Foster carer group list of key themes
VI. Interview mind map
VII. Interview mind map - colour coded.

## Appendix I - Initial Brainstorm



## Appendix II - Interview Questions

To spend time introducing how the interview will be conducted - timings, information sheet and consent verification, anonymous, etc.; some personal information will be discussed to enable us to think about your relationship with others.

1. Tell me about your experiences of working with UASC? Is there one example that stands out in your mind that you can tell me about?

- How did you come to work with them? What was the referral process?
- How do you feel when working with them? What do you notice, if anything, within yourself?
- Gender mix/age range/where from?
- What further difficulties/risks are identified?
- Noticeable benefits and outcomes from your intervention/work with them overall?

2. Can you tell me how/if you think your personal characteristics impact upon the work you do/have done with these YP?

- Class/Race/Background
- Impact/Influence upon your work/working relationships?
- Same/Difference – Barriers and advantages?
- Conflicts/Stirring within self – Privilege/guilt/Compensation/Complexities.

3. Tell me about the other services that were available to the UASC? What do you think has an impact upon the services they have access to or want to access? How?

- Were they helpful?
- What was the UASC perception/thoughts of these services?
- How easy were they to access?
- What did you identify was missing? What was asked for but wasn't available?

(… How are you left feeling after this conversation? Has anything been brought to your attention that maybe you had not considered before?)

(… Any other thoughts/questions?)

Thank you and an explanation of what will happen next – Summary of finding will be sent to you once data has been analysed.

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4. What words/associations come to mind when you hear/think about UASC?

- What does UASC mean to you?
- Where do you think these have come from?

5. What is your impression of how these young people are regarded within the local area? Are there any similarities/differences to indigenous children? Are they worked with differently?

Probes

i. What are the trends?
ii. Distances to services
iii. Language/cultural barriers
iv. Mental health
v. Engagement
vi. Funding
vii. Media influences
viii. Support/Family
ix. Complexities
x. Faith/Religion

6. What is your perception of how many UASC there are in the UK and how this then fits in with [the local area]?

7. How do you think [the local area] can improve the way in which it looks after its UASC?

*(Asylum applications (including dependants) in 2017 = 26,350 – 14% decrease compared to the year before)*

*(Including dependants, the number of people granted asylum or another form of protection (such as humanitarian protection or discretionary leave) in 2017 was 8,555.)*

*(Of these, 2,774 were children (under 18 years old). (3,175 = 2016 and 3,253 = 2015)*

*(Between April 2016 and March 2017 39 UAMs were located in [the local area] and subsequently accommodated by [the local] Council.)*

*(Since April 2017 a further 60 unaccompanied minors have been located in the city and [the local] Council are now looking after 68 unaccompanied minors and supporting a further 29 as care leavers (stats from Jan 2018)).*

8. How are you left feeling after this conversation? Has anything been brought to your attention that maybe you had not considered before?

9. Any other thoughts/questions?

Thank you and an explanation of what will happen next – Summary of finding will be sent to you once data has been analysed.

## Appendix III - Participant information sheet – Foster Carers

**University of East London**
Docklands Campus, London, E16 2RD

**Research Integrity**

The University adheres to its responsibility to promote and support the highest standard of rigour and integrity in all aspects of research; observing the appropriate ethical, legal and professional frameworks.

The University is committed to preserving your dignity, rights, safety and well-being and as such it is a mandatory requirement of the University that formal ethical approval, from the appropriate Research Ethics Committee, is granted before research with human participants or human data commences. This study has received formal approval from UREC and is funded by the UEL.

**Director of Studies**
Barbara Harrison
Tavistock Centre, 120 Belsize Lane, London, NW3 5BA
Bjharrison6@gmail.com

**The Principal Investigator**
Hayley Lawrence

**Title of Programme**
Professional Doctorate in Child Psychoanalytic Psychotherapy (D.Ch.Psych.Psych)

**Partner Educational Establishment**
Tavistock and Portman NHS Foundation Trust
120 Belsize Lane, London, NW3 5BA, 02074357111

**Consent to Participate in a Research Study**

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

**Project Title**

Exploring the challenges for the care network of providing therapeutic support for Unaccompanied Asylum Seeking Children

**Project Description**

Whilst working within the Looked After Children's Team (LAC) as part of my placement, I noticed that referrals concerning Unaccompanied Asylum Seeking Children (UASC) were increasing but that access to direct work with clinicians was rare. There are several examples across the UK where direct work is successful in treating a number of mental health complaints within this group of individuals and their support networks too. So, I wanted to investigate how and why this differs in my service. I want to find out more about the experiences of working and living with these young people who have experienced high levels of trauma, and whether this subsequently has an impact/influence upon the therapeutic work/support that is or is not being offered.

**Your Contribution**

This research endeavours to explore the views of those who live and work closely with unaccompanied asylum seeking children, and could provide an interesting insight into an area which to date has had a relatively small amount of investigation.

I will be looking to recruit 4-6 couples who currently have an unaccompanied young person placed with them. You would need to attend 6 group sessions which would last for 1 hour held by me and a co-facilitator (Susana Amez – Child and Adolescent Psychotherapist). Within this group I hope to encourage thinking about the dynamics within the foster placement and the impact of living with unaccompanied young people; what are the positives, the difficulties, and relationships like, etc.

These sessions will be audio-recorded and later transcribed. The first session will be introductory to find out about you, your background and the unaccompanied young person you currently have in placement. From this initial discussion issues, needs and experiences can be mapped and an idea of what the group wants to get out of the experience can be explored. This session will also enable us to negotiate the frequency and timings of sequential sessions; I expect these to be fortnightly.

Feedback will be collected within the sixth group session to ascertain any shifts in your thoughts and perceptions, what was helpful about the support groups or not so, and if you feel there has been a shift in how you communicate and relate with the young person residing with you.

**Potentially adverse experiences**

Some of the discussions in the support group may stir uncomfortable and upsetting topics which may be distressing for you. There will be space given within the group to discuss and think about this, but further support can also be sought after the session via a 1:1 appointment in person or across the phone with the researcher. This conversation will not be audio-recorded but its content may be used within the over-all study unless you state otherwise. The Social Worker and/or Family Placement Social Worker may also be contacted if further support is required; you will be informed about this before contact is made.

**Confidentiality of the Data**

The small sample size of the project may have implications on the individual's anonymity. However, steps will be taken to try and maintain as much anonymity and confidentiality as possible. Such as, all written information about staff and carer participants, including session notes, transcripts, meeting notes and feedback, will be anonymised. Children mentioned, and staff and foster carers who take part will be given pseudonyms.

The researcher will be responsible for the secure storage of the notes after group sessions, of the audio-recordings and of the typed transcripts, ensuring that all data used for the research purposes is kept secure in an encrypted file on a password protected computer and/or within a locked filing cabinet.

Data generated in the course of the research will be retained in accordance with the University's Data Protection Policy. Where possible, participant's confidentiality will be maintained unless a disclosure is made that indicates that a participant or someone else is at serious risk of harm. Such disclosures may be reported to the relevant authorities.

**Location**

The study will be conducted within a generic CAMHService. Support group sessions will take place in the same room and at the same time each session for purposes of consistency and continuity.

**Remuneration**

No compensation will be given as part of this study.

**Disclaimer**

Your participation in this study is entirely voluntary, and you are free to withdraw at any time during the research. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason. Please note that your data can be withdrawn up to the point of data analysis – after this point it may not be possible.

**University Research Ethics Committee**

If you have any concerns regarding the conduct of the research in which you are being asked to participate, please contact:

**Catherine Fieulleteau, Research Integrity and Ethics Manager, Graduate School, EB 1.43**
**University of East London, Docklands Campus, London E16 2RD**
**(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk)**

For general enquiries about the research please contact the Principal Investigator on the contact details at the top of this sheet.

## Participant Information Sheet - Professionals

**University of East London**
Docklands Campus, London, E16 2RD

**Research Integrity**

The University adheres to its responsibility to promote and support the highest standard of rigour and integrity in all aspects of research; observing the appropriate ethical, legal and professional frameworks.

The University is committed to preserving your dignity, rights, safety and well¬-being and as such it is a mandatory requirement of the University that formal ethical approval, from the appropriate Research Ethics Committee, is granted before research with human participants or human data commences. This study has received formal approval from UREC and is funded by the UEL.

**Director of Studies**
Barbara Harrison
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Bjharrison6@gmail.com

**The Principal Investigator**
Hayley Lawrence

**Title of Programme**

Professional Doctorate in Child Psychoanalytic Psychotherapy (D.Ch.Psych.Psych)

**Partner Educational Establishment**

Tavistock and Portman NHS Foundation Trust
120 Belsize Lane, London, NW3 5BA, 02074357111

**Consent to Participate in a Research Study**

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

**Project Title**

Exploring the challenges for the care network of providing therapeutic support for Unaccompanied Asylum Seeking Children

**Project Description**

Whilst working within the Looked After Children's Team (LAC) as part of my placement, I noticed that referrals concerning Unaccompanied Asylum Seeking Children (UASC) were increasing but that access to direct work with clinicians was rare. There are several examples across the UK where direct work is successful in treating a number of mental health complaints within this group of individuals and their support networks too. So, I wanted to investigate how and why this differs in my service. I want to find out more about the experiences of working and living with these young people who have

experienced high levels of trauma, and whether this subsequently has an impact/influence upon the therapeutic work that is or is not being offered.

**Your Contribution**

This research endeavours to explore the views of those who live and work closely with unaccompanied asylum seeking children, and could provide an interesting insight into an area which to date has had a relatively small amount of investigation.

I plan to interview professionals who would usually be within the network of an unaccompanied minor; social worker, family placement social worker, CAMHS professional for example. Key themes will then be highlighted from the analysed data. Interviews with these professionals may be a way to collect some, even if limited material on these young people who are not being interviewed directly for this study. Drawing on their links and having insight into previous conversations, interactions and exchanges they have had with these young people may shed light upon what their thoughts and experiences have been.

You will be asked a series of open questions in the format of a semi-structured interview which will last no longer than 1 hour. Notes will be taken during these interviews and used in data analysis to gain insight and understanding from the perspectives of the professional network around these young people. What are the dynamics that materialise and how these have an impact upon how a young person is cared for?

**Potentially adverse effects**

Some questions and conversations may stir uncomfortable and upsetting topics which could be distressing to the individuals taking part. There will be a space given outside of the interview to discuss and think about this if the researcher feels it would be helpful or if it is requested by the participant. This conversation will not be audio-recorded but its content may be used within the over-all study unless stated otherwise. Your management team can also be contacted for further support if further required.

**Professional relationships**

If you have a professional relationship with the researcher, your participation or non-participation in the project will not impact on the professional workings afterwards.

**Confidentiality of the Data**

The small sample size of the project may have implications on the individual's anonymity. However, steps will be taken to try and maintain as much anonymity and confidentiality as possible. Such as, all written information about staff and carer participants, including session notes, transcripts, meeting notes and feedback, will be anonymised. Children mentioned, and staff and foster carers who take part will be given pseudonyms.

The researcher will be responsible for the secure storage of the notes after group sessions, of the audio-recordings and of the typed transcripts, ensuring that all data used for the research purposes is kept secure in an encrypted file on a password protected computer and/or within a locked filing cabinet.

Data generated in the course of the research will be retained in accordance with the University's Data Protection Policy. Where possible, participant's confidentiality will be maintained unless a disclosure is made that indicates that a participant or someone else is at serious risk of harm. Such disclosures may be reported to the relevant authorities.

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The study will be conducted within a generic CAMHService. Support group sessions will take place in the same room and at the same time each session for purposes of consistency and continuity.

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**Catherine Fieulleteau, Research Integrity and Ethics Manager, Graduate School, EB 1.43**
**University of East London, Docklands Campus, London E16 2RD**
**(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk)**

For general enquiries about the research please contact the Principal Investigator on the contact details at the top of this sheet.

## Appendix IV – Consent Form for Foster Carers

### UNIVERSITY OF EAST LONDON

**Consent Form for Foster Carers**

**Consent to Participate in a Programme Involving the Use of Human Participants.**

*Exploring the challenges for the care network of providing therapeutic support for Unaccompanied Asylum Seeking Children.*

Researcher:
Hayley Lawrence

Please tick as appropriate:

| | YES | NO |
|---|---|---|
| I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me. | | |
| I understand that the support groups will be audio recorded for purposes of gathering data for this study and I confirm I give my consent for this. | | |
| I understand that the small sample size of the project may have implications on my anonymity and confidentiality in this study. However, I understand the researcher will take steps to try and maintain as much anonymity and confidentiality as possible. | | |
| I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study, supervisors and examiners will have access to the data. | | |
| I understand that maintaining strict confidentiality is subject to the following limitations:<br><br>Where possible, participants' confidentiality will be maintained unless a disclosure is made that indicates that the participant or someone else is at serious risk of harm. Such disclosures may be reported to the relevant authority. | | |
| I understand and give consent that anonymized quotes may be used in publication of this study. | | |

| | | |
|---|---|---|
| If published, you have the option to be named in publications following this study. Do you give consent for this? | | |
| I understand that the research findings will be published and disseminated within a thesis and may be presented to the service for purposes of feedback and learning. | | |
| I give permission for the data gathered in this study to be used in future research by X, to develop the service and promote equal opportunities and access where appropriate. | | |
| I give permission to be contacted for future research studies by X. | | |
| It has been explained to me what will happen once the programme has been completed – Research findings will be sent to me via post in the format of a summary. | | |
| I understand that my participation in this study is entirely voluntary, and I am free to withdraw at any time during the research without disadvantage to myself and without being obliged to give any reason. I understand that my data can be withdrawn up to the point of data analysis and that after this point it will not be possible as all names will be anonymised. All verbalized material will be redacted from transcripts. | | |
| I understand that if I need extra support or advice following any of the support groups, this can be organised by the lead researcher. Conversations had within these additional sessions will not be audio-recorded, but I understand that their content will be documented in note form and may be used within the study, unless I state otherwise. | | |
| I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications. | | |

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Investigator's Name (BLOCK CAPITALS)

……..

Investigator's Signature

…… Date: ……

**Consent Form for Professionals**

**UNIVERSITY OF EAST LONDON**

**Consent Form for Professionals**

**Consent to Participate in a Programme Involving the Use of Human Participants.**

*Exploring the challenges for the care network of providing therapeutic support for Unaccompanied Asylum Seeking Children.*

Researcher:
Hayley Lawrence

Please tick as appropriate:

| | YES | NO |
|---|---|---|
| I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me. | | |
| I understand that the small sample size of the project may have implications on my anonymity and confidentiality in this study. However, I understand the researcher will take steps to try and maintain as much anonymity and confidentiality as possible. | | |
| I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study, supervisors and examiners will have access to the data. | | |
| I understand that maintaining strict confidentiality is subject to the following limitations:<br><br>Where possible, participants' confidentiality will be maintained unless a disclosure is made that indicates that the participant or someone else is at serious risk of harm. Such disclosures may be reported to the relevant authority. | | |
| I understand and give consent that anonymized quotes may be used in publication of this study. | | |
| If published, you have the option to be named in publications following this study. Do you give consent for this? | | |

| | | |
|---|---|---|
| I understand that the research findings will be published and disseminated within a thesis and may be presented to the service for purposes of feedback and learning. | | |
| I give permission for the data gathered in this study to be used in future research by X, to develop the service and promote equal opportunities and access where appropriate. | | |
| I give permission to be contacted for future research studies by X. | | |
| It has been explained to me what will happen once the programme has been completed – Research findings will be sent to me via post in the format of a summary. | | |
| I understand that my participation in this study is entirely voluntary, and I am free to withdraw at any time during the research without disadvantage to myself and without being obliged to give any reason. I understand that my data can be withdrawn up to the point of data analysis and that after this point it will not be possible as all names will be anonymised. | | |
| I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications. | | |

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Investigator's Name (BLOCK CAPITALS)

……..

Investigator's Signature

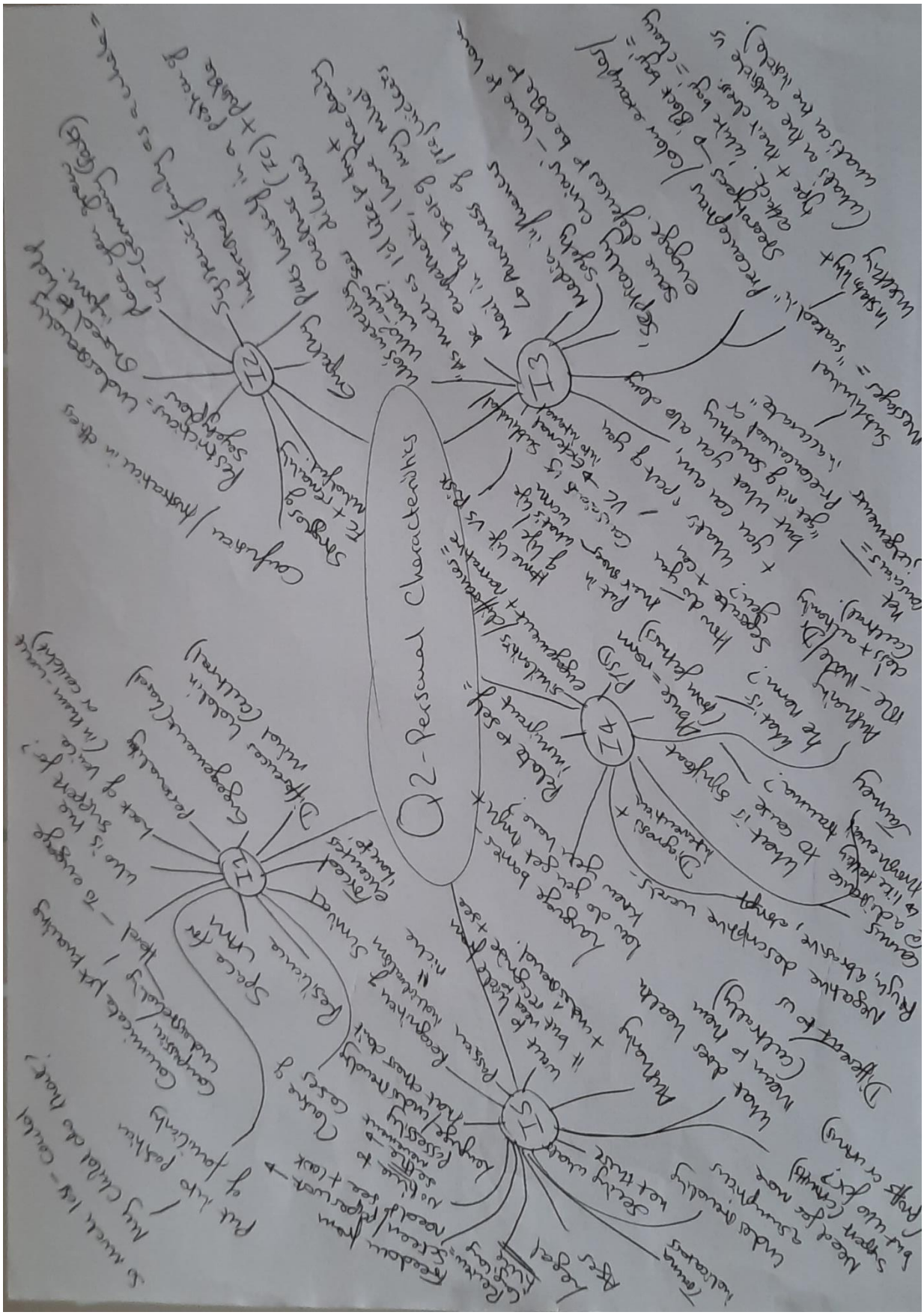
……

Date: …….

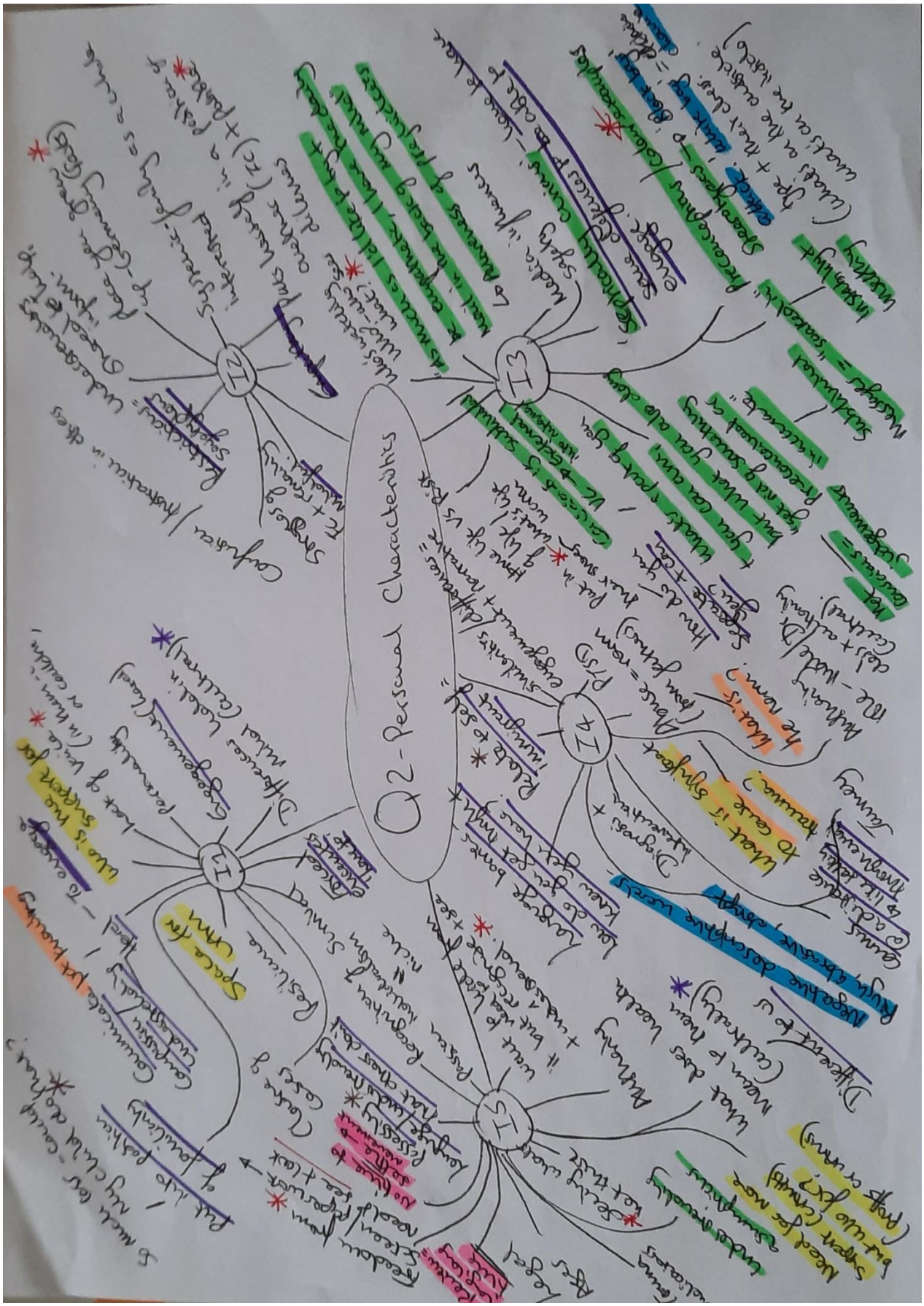
## Appendix V - Foster carer group list of key themes

- Education – school/home – where/What type? Language/sex education
- Safety plans
- Expectations – YP/SW/FC
- Journey
- Asylum process - Home Office - how does it work?
- Trust (both ways)
- Stories
- Religion
- Adapting - do you? How?
- Effect of others in home who aren't UAM
- Children at home
- Women/men
- Cultural clashes/Racism
- Class and status
- Trauma
- Help/support
- Language barrier
- Health – UMA experience
- Interpreter's - inappropriate translations/behaviours
- Impact of location
- Prospects
- Offender/Offences
- Differences/Inconsistencies in treatment plans and processes
- UAM/LAC - similarities and differences
- Boundaries
- Transparencies
- What's important to whom
- Contact – family/kinship
- Individuality
- Sexuality/relationships
- Other services available - how to refer/contact?
- Emotional rollercoaster
- Respite/share with others
- Sharing information
- What feelings get provoked – “mug”
- Food/culture - Ramadan (education and culture)
- Family values - conflicts
- House rules/boundaries
- Changes in YP views
- Endings
- Other people’s perceptions (community)
- Media
- Activities

## Appendix VI - Interview Mind Map example



## Appendix VII - Interview Mind Map – Colour coded example



## Appendix VIII – UREC Letter

University of East London
Pioneering Futures Since 1898

5th November 2020

Dear Hayley,

| | |
|---|---|
| Project Title: | Exploring the challenges for the care network of providing therapeutic support for Unaccompanied Asylum Seeking Minors |
| Researcher: | Hayley Lawrence |
| Principal Investigator | Barbara Harrison |
| Amendment reference number: | AMD 2021 03 |
| Original approved application reference number: | UREC 1718 13 |

I am writing to confirm that the application for an amendment to the aforementioned research study has now received ethical approval on behalf of the University Research Ethics Sub-Committee (URES).

Should you wish to make any further changes in connection with your research project, this must be reported immediately to URES. A Notification of Amendment form should be submitted for approval, accompanied by any additional or amended documents: https://uelac.sharepoint.com/sites/GraduateSchool/SitePages/Researc.aspx

**Approved Research Site**

I am pleased to confirm that the approval of the proposed research applies to the following research site:

| Research Site | Principal Investigator / Local Collaborator |
|---|---|
| Falcon House, St. James" Hospital, Portsmouth | Barbara Harrison |

University of East London

Pioneering Futures Since 1898

| Summary of Amendments |
| --- |
| **Amendment: Change of title**<br><br>From:<br><br>Exploring the challenges for the network of providing therapeutic support for Unaccompanied Asylum Seeking Children<br><br>To:<br><br>Exploring the challenges for the care network of providing therapeutic support for Unaccompanied Asylum Seeking Minors |

Ethical approval for the original study was granted on 13th February 2018.

In view of the Covid-19 pandemic, the University Research Ethics Sub-Committee (URES) has taken the decision that all face-to-face projects that include participant interactions should cease to use this method of data collection. For example, in person participant interviews or focus groups. The University supports Microsoft Teams for remote work. New research projects must not recruit participants using face-to-face interactions and all data collection should occur remotely. These regulations should be followed until further notice by URES.

Approval is given on the understanding that the University's Code of Practice for Research and Code of Practice for Research Ethics is adhered to:
https://uelac.sharepoint.com/sites/GraduateSchool/SitePages/Researc.aspx

With the Committee's best wishes for the success of this project.

**Please ensure you retain this letter, as in the future you may be asked to provide evidence of ethical approval for the changes made to your study.**

Yours sincerely,

Fernanda Silva

Fernanda Silva
Administrative Officer for Research Governance
University Research Ethics Sub-Committee (URES)
Email: researchethics@uel.ac.uk