ELEANOR G. FERRIS BSc Hons

WORKING RELATIONALLY WITH LOOKED AFTER CHILDREN: THE ROLE OF RESIDENTIAL THERAPEUTIC CARERS

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Summary of the MRP Portfolio

Section A is a literature review evaluating the role of Therapetuic Care Workers (TCWs) and Therapeutic Foster Carers (TFCs) working relationally with a sub-group of Looked After Children (LAC) who are highlighted as having intense emotional and behavioural needs. These LAC are thought to benefit from living in specialist, therapeutic placements where carers work relationally. However, to date, there is no known review evaluating relational residential interventions or the role of TCWs and TFCs. Therefore, literature exploring the theoretical underpinnings of the work, and the emotional impact and protective factors involved in the carer role is considered. Implications for future research and clinical practice are suggested.

Section B describes a qualitative study using Interpretative Phenomenological Analysis, which explores how TCWs experience their work with LAC. Nine participants undertook semi-structured interviews. Participants described their work as a rewarding experience, where they worked within a supportive structure and utilising psychodynamic concepts, such as countertransference. Due to a personal investment in the role, and the emotive context in which they work, participants also experienced their role as emotionally challenging. Implications for clinical practice and further research are discussed.

Section C summarises critical reflections on the process of conducting the research project, including areas of learning and development for the researcher, implications for training, clinical practice and further research.

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WORKING RELATIONALLY WITH LOOKED AFTER CHILDREN: THE ROLE OF RESIDENTIAL THERAPEUTIC CARERS

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Abstract

Objectives. This review sought to systematically search, summarise and critique literature on relational work between carers and children in therapeutic residential childcare. The review focuses on the role of therapeutic residential carers working with Looked After Children (LAC).

Methods. Electronic databases (ASSIA, Medline, PsychInfo, Ovid, Cochrane) were searched using a broad range of terms relating to the implications of therapeutic residential childcare for carers.

Results. Of 5658 records screened, 25 relevant papers were reviewed. Information regarding factors pertaining to the facilitation of relational work, together with the emotional impact of the role and the protective factors of the role, were considered. Findings were discussed in relation to theoretical models underpinning relational therapeutic childcare (e.g. attachment theory and mentalisation). Most papers relied on case studies or were descriptive and conceptual.

Conclusions. Findings showed that carers aimed to build secure attachments with the children. The need for self-reflection within carers working in therapeutic communities was also highlighted given the highly emotive context of their work, and the importance of supervision and training was indicated. Implications for future research and clinical practice were suggested.

Introduction

This is a review of the literature regarding the role of therapeutic residential carers working with Looked After Children (LAC). The review begins by highlighting common early experiences of LAC and reasons for them being taken into care. The therapeutic residential care provided to a group of LAC requiring specialist support is then outlined in order to contextualise the review.

Profile of Looked After Children

LAC is a term used to describe children and young people under the age of 18 who are accommodated or looked after by a local authority (Department for Education [DfE], 2012a). These children are subject to a range of legal orders, which specify the involvement of the state in assuming some form of 'parenting' responsibility for the child. By March 2012, there were 67,050 LAC, an increase of 13 per cent compared to March 2008 (DfE, 2012a). While 75 per cent of LAC were in foster care, other placements included kinship care (where the main carer is a member of the child's extended family), residential homes, residential schools or secure unit settings (DfE, 2012a).

Children are removed from their homes into local authority care when a court determines that the welfare threshold has been met following neglect and/or physical, emotional or sexual harm (Department of Health [DH], 2010). Typically, LAC will have been exposed to a number of risk factors before being removed into care. These can include poverty, low income, parental relationship breakdown, substance misuse and chaotic or unstable patterns of care (Sweeney, 2008; Viner & Taylor, 2005). Some LAC have been exposed to frightening and traumatic experiences such as domestic violence. Most children cannot successfully process these experiences, which can result in negative long-term outcomes (DH, 2010).

Outcomes for LAC

Emotional and behavioural needs have been found to be significantly higher for LAC compared to the non-LAC population (Richards, Wood & Ruiz-Calzada, 2006).

Ford, Vostanis, Meltzer and Goodman (2007) conducted a national study into the mental health of LAC. They examined socio-demographic characteristics and psychological presentation by type of placement among 1453 LAC and compared these with 10,428 deprived and non-deprived children living in private households. LAC had higher levels of psychopathology, educational difficulties and neurodevelopmental disorders, with the prevalence of psychiatric disorders particularly high among those living in residential care. Similar findings were attained in other studies conducted in the United Kingdom (UK; Anda et al., 2006; Cousins, Taggart & Milner, 2010; DH, 2010; McCann, James, Wilson & Dunn, 1996; Sweeney, 2008).

Sweeney (2008) reviewed studies evaluating the scale, symptomatology and determinants of mental health problems in LAC. Children in residential care were found to have higher incidence of mental health problems compared to those in foster care. Those in residential care were found to have the most complex psychological difficulties, characterised by attachment difficulties, relationship insecurity, sexualised behaviour, trauma-related anxiety, conduct problems, defiance and hyperactivity.

LAC and Therapeutic Residential Care

The DH produced guidelines on abuse prevention and identification of child maltreatment (DH, 2009). These guidelines emphasised that LAC in residential care

are a particularly vulnerable group. The policy guidelines highlighted that successful interventions were those that were long-term, intensive, multifaceted and tailored to the assessed needs of the individual (DH, 2010; McQueen, Itzin, Kennedy, Sinason & Maxted, 2009).

It has been suggested that LAC with the most challenging emotional and behavioural difficulties can benefit significantly from placements in Therapeutic Communities (TC) because such establishments are designed to meet their specific needs (McQueen et al., 2009). Children in this subgroup have often experienced multiple placement breakdowns due to carers feeling unprepared for, or unable to manage, the intensity of the young person's emotional and behavioural needs (Craven & Lee, 2006; Dockar-Drysdale, 1990; Golding, 2010; Kohlstaedt, 2010; Richardson & Joughin, 2000).

Such establishments differ from specialist therapeutic foster placements, which include a high level of support and training for carers who work with children who are often difficult to engage (Social Care Institute for Excellence, 2004). The intense emotional and behavioural needs of this LAC subgroup with the most severe difficulties can often be too great even for the specialist, experienced therapeutic foster carer (McQueen et al., 2009). The contention is that this group of children benefit from living in a TC, which constitutes a therapeutic milieu (Collie, 2002; McQueen et al., 2009). Such environments enable therapeutic care workers (TCWs)[1] to address the needs of the most emotionally challenged children. TCWs are supported to think in psychologically-minded ways, receive ongoing training and supervision, and hold forums where issues associated with working at a deep

[1] Other professional titles that can encompass this role are 'residential social worker' and 'therapeutic residential social worker'. However, the term TCW will be used throughout this paper.

emotional level with these children can be continuously contained and their emotions processed (Tomlinson, Gonzalez & Barton, 2011). The National Institute of Clinical Excellence (NICE) guidelines for LAC (DH, 2010) support this through advocating stable placements and nurturing relationships.

Aims of this Review

Relational interventions, commonly utilised within TCs, place emphasis on the therapeutic relationship between children and carers. It has been argued that a placement within a TC may have the potential to positively change the trajectory of a child's emotional development (Tomlinson, Gonzalez & Barton, 2011). However, research into relational residential interventions and the role of TCWs is lacking (DH, 2010). Given TCWs potential to facilitate positive long-term outcomes for LAC, it is concerning that the current finance driven social and political context may pose a threat to funding for TC placements (DfE, 2012b). This review explores the literature on the TCW role, to establish a comprehensive overview of how TWCs apply theory to their practice and to consider the implications on their wellbeing. The review also seeks to inform TCWs and other carers wishing to improve their practice.

The review will explicitly explore the following questions:

1. What theories underpin relational work with LAC in TCs?
2. How do TCWs apply theory to practice?
3. What are the helpful and protective factors that enable TCWs to work relationally with LAC?
4. What is the impact of working in TCs on the emotional wellbeing of TCWs?

Method

A systematic search was conducted to identify literature addressing the four research questions. For full details of the search terms and inclusion criteria, see Appendix A.

Nine empirical papers met the inclusion criteria, seven of which were practice-based clinical case studies. A further ten theoretical practice-based papers were identified, although formal qualitative or quantitative analysis was not conducted. However, these papers were included in the review due to the insight that they could potentially provide in such an under-researched area (Cohen, Stavri & Hersh, 2004).

Given the methodological limitations of the research, including issues surrounding reliability and validity, a second literature search was conducted. Literature pertaining to specialist therapeutic foster carers (TFCs; as opposed to all foster carers) was searched for, as their settings are most closely aligned with therapeutic residential care in terms of the intense emotional needs of the LAC, and the training of, and impact upon staff (McQueen et al., 2009). Additionally, by reviewing this related literature of TFCs, it was hoped that the suggested implications for carers might promote transferability of skills.

Search terms were modified to focus upon TFCs rather than TCWs (Appendix A). Studies were included in the review if the intervention was classified as a therapeutic foster care intervention (Craven & Lee, 2006; Turner & Macdonald, 2011). Six further studies were identified through this search.

In total, twenty-five papers, sixteen empirical and ten theoretical, were identified through the two searches (see Appendix B). The reference lists of identified papers were cross-referenced to ensure sufficient inclusion of wider theoretical bases (e.g. attachment theory; Bowlby, 1969).

Review

Initially, practice-based theoretical papers are summarised and critiqued. Theoretical underpinnings of relational work with LAC in TCs are then presented and summarised, providing clarity for the basis of relational interventions reviewed later. Subsequently, an overview of the literature for both carer groups is provided (relating to the review questions), followed by a summary and critique. Suggestions regarding further research are proposed.

Practice-based Papers

Most articles (n=8; Bloom, 2005; Collie, 2008; Cross, 2010; McLellan, 2010; Rose, 2002; Sprince, 2002; Tomlinson, 2005; Watson, Gould, Sullivan, Cockerill & Officer, 2006) offered descriptions of TCs. Salient themes across these papers described principles of working in TCs, highlighting the specific requirements of TCWs. These included: Principles regarding the value of group work and community meetings as a medium for therapeutic work; commitment to medium/long-term individual therapeutic relationships with the children; commitment to a personal and involved style of working; the value of the physical and personal 'environment' in contributing to the work; the use of psychodynamic and/or systemic thinking and commitment to staff support, supervision, and consultancy.

Provision of psychotherapy was argued to be an important factor in TC treatment in all papers. Consultation with psychotherapists was considered to facilitate a staff culture which encouraged self-reflection and explored group dynamics (Bloom, 2005; Cant, 2002; Collie, 2008; Cross, 2010).

Two papers (Cooper, 2002; Ward, 2002) described the concept of 'opportunity-led work', described as holistic, systemic practice within TCs where

therapeutic work was not confined to the traditional 'therapeutic hour.' This was distinguished from planned or scheduled activities and was understood as involving TCWs using opportunities for communication and insight on a moment-to-moment basis.

Limitations. The papers offered valuable descriptions, often conveying the immediacy and emotional quality of the work. However, the number of TCWs contributing to the papers was often low or not identified. Papers took the form of subjective, descriptive accounts, thus reducing the validity and reliability of the findings (Yardley, 2000). The authors of most papers were consultant psychotherapists within the establishments (McLellan, 2010; Sprince, 2002) or Directors (Cooper, 2002; Tomlinson, 2005; Watson et al., 2006) and some did not state their role clearly (Bloom, 2005; Cross, 2010; Rose, 2002). This limited the capacity to consider any potential for bias within the papers.

Although theoretical evidence was limited in terms of what it could add to the evidence-base, some salient themes regarding TCWs working with LAC emerged. Furthermore, theories underpinning the work of TCWs within TCs were consistently highlighted throughout the papers. These will now be described and then discussed in relation to the first and second review questions.

Theoretical Underpinning of Relational Work with LAC

Therapeutic adult communities such as the Cassel Hospital and the now closed Henderson Hospital have a long history of facilitating therapeutic milieus for the treatment of personality disorder (Loat, 2011; Dolan, Warren & Norton, 1997). A parallel can be drawn between adult and LAC TCs, in that both approaches utilise

unconscious processes. Within the reviewed literature, TCs were reported to be informed by psychoanalytic concepts (for example, projective identification and transference). Whereas adult TCs were traditionally informed by a psychoanalytic community framework, literature suggests that TCs for LAC are now more recently underpinned by mentalisation theory, which integrates empirical research with psychoanalytic theory (Fonagy & Target, 1997). Two further key theories were also highlighted as underpinning TC for LAC: Attachment (Bowlby, 1969) and resilience (Luthar, 2005).

The above theories have been found to be useful frameworks for understanding and exploring the therapeutic alliance in psychotherapy (Fonagy & Adshead, 2012; Holmes, 2011; Smith, Msetfi & Golding, 2010) and their use as an intervention for children with emotional and behavioural needs has been explored (Booth & Jernberg, 2010; Golding, 2003). Foster carers' skills in mentalising about LACs' behaviour has been argued to be an important factor in maintaining placements (Ironside, 2012).

Attachment theory. Attachment theory (AT; Bowlby, 1969) provides a framework which explicates how early relationships can impact on later social, emotional and cognitive development. Through the attachment process, the development of psychobiological attunement occurs between the infant and caregiver (Bowlby, 1969). The quality of attachment has been argued to impact upon resilience (Atwool, 2006; Jackson, Whitehead & Wigford, 2010; Matson & Coatsworth, 1998) and has been linked with competence and problem-solving skills (Cohn, 1990; George & Solomon, 1989; Matas, Arend & Sroufe, 1978).

Mentalisation. Mentalising is a form of imaginative mental activity, involving perceiving and interpreting human behaviour in terms of intentional mental

states (Fonagy & Target, 1997). It has been argued that an individual's ability to mentalise is rooted in the attribution of mental states, and that this capacity emerges through interaction with the caregiver in the context of an attachment relationship (Fonagy, Gerely, Jurist & Target, 2002). This capacity may be inhibited temporarily, or more extensively, in response to relational conflicts, acute stress or trauma (Bateman & Fonagy, 2004). Difficulties in understanding the mental and emotional states of others have been linked to the development of borderline personality disorder (Fonagy, Luyten & Strathearn, 2011), and to an increase in anger, aggression and subsequent conduct disorder (Kochanska, 2001).

LAC in need of TCs are typically those whose early experiences have been significantly shaped by fear and unpredictability, often presenting with disorganised attachment behaviours (Atwool, 2006; Main & Solomon, 1990; Schore, 2003; Trowell, 2010; Van Ijzendoorn, Schuengel & Bakermans-Kranenburg, 1999). Due to disruptions in the early attunement between the infant and primary carer, it is suggested that the child will have had little chance to experience sensitive reflection on his or her own mental states from the caregiver (Bateman & Fonagy, 2004). This often results in significant disruptions in the capacity to mentalise (Lyons-Ruth & Jacobvitz, 1999). The child is thought to internalise the emotional states of the primary caregiver, which are likely to be fearful and/or frightening (Craven & Lee, 2006; Fonagy, Gergely, Jurist & Target, 2002; Holmes, 2005; Schore, 2003).

Within a secure attachment, the carer's ability to 'mentalise' and be attuned to the infant facilitates the infant's capacity for emotional self-regulation (Schore, 2003) and development of a reflective function (Fonagy & Target, 1997; Tomlinson, Gonzalez & Barton, 2011). Critically, the child will internalise their experience of the caregiver's responses. This experience will shape the development of their inner

representation of attachment, which is a template for subsequent relationships with significant others (Fonagy & Target, 1997).

Resilience. Resilience is defined as positive adaptation in circumstances where personal, familial or environmental difficulties could impair a person's cognitive or functional abilities (Garmezy 1984; Luthar, 2005; Maston & Coatsworth, 1998; Rutter 1999). Contributions to defining resilience include studies highlighting vulnerability and protective factors (Luthar, 2006). Main risk factors identified for children include childhood abuse, neglect, death of parents or grandparents, poverty, parental psychopathology, parental separation and exposure to violence (Emery & Forehand, 1994; Garmezy, 1984; Grotberg, 1997; Luthar, 2005; Luthar & Zelazo, 2003).

Within the reviewed papers, TCs aimed to reduce risk and promote protective factors within children and their environments. These protective factors were applied to three main areas of influence, the physical and emotional qualities and traits of the child, the family context and the social environment (Bostock, 2004; Emery & Forehand, 1994; Gilligan, 2009; Grotberg, 1997; Luthar, 2005; Maston & Coatsworth, 1998; O'Connor & Rutter, 2000; Werner & Smith, 1992).

Summary

With regard to the first aim of this review, the theoretical underpinnings of relational work with LAC are AT (Bowlby, 1969), resilience theory (e.g. Luthar, 2006) and mentalisation (e.g. Fonagy & Target, 1997). Empirical research is now reviewed in order to explore how carers have implemented these theories in their practice.

Empirical Research

Implementing theory in practice.

TCWs. Eight papers considered how TCWs implement theory in practice. These included clinical case studies (n=7), one study wherein residents were interviewed and another study wherein TCWs were interviewed.

The clinical case studies (Cant, 2002; Collie, 1996; Farragher & Yanosy, 2005; Kohlstatedt, 2010; Tolmacz, 2003; Tziotziou, Dimitris, Karapostoli & Tsegos, 2006; Whitwell, 1998) comprised detailed descriptive accounts of individual children during their placement. Community Directors (n=4), a trainer, and a Consultant Psychotherapist described how individual children were engaged by TCWs in deeply connected relationships in order to develop a secure attachment and learn new, positive ways of relating to others. Four papers (Cant, 2002; Collie, 1996; Tolmacz, 2003; Whitwell, 1998) reported on how staff used AT (Bowlby, 1969) and self-awareness of counter-transference in their work, with Kohlstaedt (2010) describing the relational work as taking the form of positive, secure relationships between staff and children. Collie (1996) described a TCW using supervision to bring into awareness the role of projective identification (Ogden, 1982) in relational work with a child.

Across all papers, communication between staff was regarded as necessary for the child being held in mind. Communication between staff was encouraged to reduce 'splitting' (Ogden, 1982) and 'acting out' (Dockar-Drysdale, 1990) among adolescents. Carers also needed to be able to identify unconscious feelings in the children with whom they worked (Cant, 2002; Collie, 1996; Tolmacz, 2003). All papers described TCWs needing to create positive emotional intensity and attunement with the children.

With reference to Yin's (1993) criteria for case studies, all papers were unstructured and no formal measures were used, thus limiting the ability to infer validity. Although information was clearly described over an extended time frame, often only one investigator collected data, thus introducing potential for bias. Data collection methods were not described and possible biases, methodological strengths and limitations were rarely acknowledged.

In interviews with residents and ex-residents (n=9) of a TC, Carter (2011) reported on the experiences of children following their placements. Participants described their increased ability to relate well to others both individually and in groups as a result of being in the TC. They reported that the important factors for change included the security they felt in their relationships with kind, caring staff, and their belief that the staff wanted to work with them and were able to understand and tolerate difficult behaviours.

Moses (2000) interviewed 25 TCWs who applied AT to their work with 126 children aged six to 18 years. Analysis took the form of 'a synthesis of analytical and interpretive procedures' (Moses, 2000; p.479). However, the exact methodology was not described. Practice principles were associated with AT, with TCWs giving examples such as, having a willingness to respond, ability to perceive and understand the child's signals and a sense of effectiveness in meeting their needs.

With reference to Yardley's (2000) validity criteria, conclusions drawn from the two qualitative papers (Carter, 2011; Moses, 2000) should be tentative. The small sample sizes and the authors being associated with the organisation potentially biased the findings (Williams & Marrow, 2009). No formal qualitative methodological approaches were utilised; responses were simply reported verbatim. The authors also failed to outline a research question or clarify what was being investigated or why.

Lastly, quality control methods were not used and some caution was therefore required when interpreting the findings (Yardley, 2000).

TFCs. Holmes and Silver (2010) reported on a group intervention for TFCs combining aspects of parenting programmes (Sanders, 1999; Webster-Stratton, 1998) with AT (Bowlby, 1969) and social learning theory (SLT; Bandura, 1977). SLT describes individuals learning through cognitive processes how to behave through being with and observing others within a particular social context. Analysis of pre- and post-intervention questionnaires for the group supported the hypothesis that group interventions based on AT and SLT can facilitate positive carer-child relationships (Forehand & McMahon, 1981). An increase in parental confidence was attributed to acquisition of knowledge and support from facilitators and parents in the group. A limitation of the study was that no control group was used therefore it was not possible to ascertain whether change was due to the described intervention or to extraneous, uncontrolled variables (Meltzoff, 1998). Furthermore, the authors implemented the intervention, which may have introduced bias.

Bywater et al. (2011) aimed to investigate the efficacy of the Incredible Years parenting programme (Webster-Stratton 1998) in supporting foster carers to manage difficult behaviour. Measures were administered at baseline and six-month follow-up to participants (n=29) who undertook the intervention. The same measures were administered to a control group of carers and carers (n=14) where the intervention was not applied. Measures included The Parenting Scale (Arnold, O'Leary, Wolff & Acker, 1993) and the Beck Depression Inventory (Beck & Steer, 1993). A reduction in childrens` difficult behaviours and improvements in foster carers' confidence, stress, and depression were demonstrated.

Three papers (McNeil, Herschell, Gurwitch & Clemens-Mowrer, 2005; Timmer, Urquiza & Zebell, 2006b; Timmer, et al., 2006a) described the effectiveness of parent-child interaction therapy (PCIT) for foster carers and children. PCIT is informed by SLT and provides intensive interaction training to change the pattern of the disrupted parent-child relationship. Foster parents are taught to attend to children's positive behaviours and to avoid more controlling methods.

Timmer et al. (2006a) described a single case study involving a young boy exhibiting aggressive behaviour. A reduction in problem behaviours following PCIT was observed. Timmer et al. (2006b) described the effectiveness of PCIT for 75 non-related foster carers, compared with 98 non-abusive parents, reporting decreases in children's behaviour problems and caregiver distress. McNeil et al. (2005) reported on the effectiveness and satisfaction for 30 foster children and their parents following PCIT. Parents reported behaviours to be improved post-treatment and at five-month follow-up.

Across papers, the skills acquired by TFCs which facilitated positive relationships with children included, following the child's lead when playing, attending to positive behaviours, consistently praising, increased patience and implementing 'time-out' when necessary. Results indicated that children's behaviour improved as a result of the training and parents' reports reflected a shift in their attitudes towards their children. However, these studies did not use control or comparison groups and authors' subjective accounts of clinical change were presented, which may have introduced bias.

Westermark, Hansson and Vinnerljung (2007) interviewed 28 Swedish foster carers regarding their experience of working within Multidimensional Treatment Foster Care (MTFC). MTFC is a treatment programme based on SLT

(Bandura, 1977) which aims to improve the outcomes for young people with serious behavioural problems by giving them the skills to return to live with their families or move successfully on to long-term stable fostering arrangements. Foster carers have access to support from supervisors 24 hours a day, a weekly support group, and specialised training in the MTFC approach. Its evidence-base demonstrates a reduction in number of placements in residential care, child problem behaviour, placement disruption and care costs (Aos, Lieb, Mayfield, Miller & Tennucci, 2004; Chamberlain, 2003). The availability of manageable 'treatment tools' were important elements in carer satisfaction with the programme. The findings were limited in that standardised instruments were not used, generalisability is compromised by the use of a small Swedish sample, and no information about attitude change over time or follow-up period was considered, limiting conclusions regarding long-term outcomes.

Summary

The evidence suggests that TCWs aimed to build secure, positive attachments with LAC. They sought to create positive emotional interactions and to attune with the children emotionally, to show consideration for unconscious processes (e.g. counter-transference), and to use supervision, training and staff support alongside their work. TFCs attempted to facilitate positive parenting relationships through structured interventions, which drew upon AT (Bowlby, 1969) and SLT (Bandura, 1977), and used supervision and peer support to reflect on these interventions.

Protective Factors

TCWs. Cant (2002) described the necessity of TCWs consulting with resident psychotherapists in order to process unconscious dynamics. Further training to

develop understanding of unconscious processes was highlighted as important (Cant, 2002; Collie, 1996; Kohlstatedt, 2010; Whitwell, 1998). Clinical supervision, training, group work and a supportive staff team were all identified as important factors in helping TCWs to apply theory to practice (Kohlstatedt, 2010). Tziotziou et al. (2006) indicated that a large staff team could reduce the emotional burden on individual carers.

TFCs. In studies described above, Holmes and Silver (2010), and Bywater et al. (2011) used thematic content analysis of participants' feedback following group interventions. A common theme was the emotional support gained from sharing experiences with others in similar situations.

Timmer et al. (2006b) reported how training could reduce stress and increase understanding and confidence in foster carers. They also found that distressed foster carers were more likely to stay in treatment than distressed biological parents who were more likely to drop out.

McNeil et al. (2005) described high rates of satisfaction, both immediately following training and at five-month follow-up. It could be hypothesised that PCIT provided foster carers with therapeutic support which was otherwise not readily available. This was also suggested by Westermark, Hansson and Vinnerljung (2007), who found that the majority of participants expressed confidence in the structure and content of the programme. Receiving daily support and feedback was an important reason for carers to remain within the programme.

Summary

Helpful and protective factors for TCWs involved the use of supervision, training and group work to process unconscious dynamics. TFCs also described the emotional support provided by sharing their experiences with others.

Emotional Impact

TCWs. Farragher and Yanosy (2005) described a residential programme in the United States of America experienced in traumatised young people. Details were provided regarding the training and supervision offered to staff to assist them to recognise and process the range of emotions and dynamics occurring in such a context. The authors also reported on a TCW working in an intense and volatile setting, where supervision was inadequate. A case example was used to illustrate that staff could be vulnerable and inadvertently "play into children's re-enactments" (pp.102), highlighting that staff awareness of such processes allowed them to depersonalise negative behaviours and avoid reacting to negative, raw feelings. The authors acknowledged the need for TCWs to tolerate anxiety, to reflect on splitting, projection and denial, and to reflect on their life experiences and how these affected relationships with children. Conclusions were tentative due to the subjective stance of the study.

The emotional impact of the TCW role was also considered in the studies described above. Carers were described as being placed under intense emotional pressure (Collie, 1996; Farragher & Yanosy, 2005; Whitwell, 1998). Emotional resilience was argued to be essential in maintaining relationships with the children, since carers were faced with aggressive outbursts and exposure to violence (Kohlstatedt, 2010; Tolmacz, 2003).

In terms of personal development, TCWs needed to be self-aware (Kohlstatedt, 2010; Tziotziou et al., 2006) and to develop an emotional capacity to facilitate the relational capacities of the LAC (Cant, 2002; Carter, 2011; Farragher & Yanosy, 2005; Kohlstatedt, 2010; Moses, 2000; Tziotziou et al., 2006). It was argued that TCWs needed to acknowledge that their attachment experiences could act as barriers to relationships (Moses, 2000) or impact on their emotional vulnerability (Farragher & Yanosy, 2005). Moses (2000) argued that high expectations could generate pressure on staff, thus highlighted supervision as intrinsic to self-reflection.

TFCs. In a study described above, Timmer et al. (2006a) evaluated a foster mother's stress. Scores on the Parenting Stress Index (Abidin, 1995) demonstrated a substantial increase in stress over time when caring for her foster child. By the end of the PCIT intervention, the parenting stress scores had reduced significantly.

Summary

Papers exploring the impact on the emotional wellbeing of TCWs highlighted the intense, volatile and unpredictable settings in which these carers worked. The pressure this placed on the staff was noted. One study pertaining to TFCs highlighted the increased stress that these carers were likely to experience. However, there was a dearth of relevant research in the papers reviewed.

Discussion of the Findings

In relation to the first aim of this review, which was to identify theories underpinning relational work with LAC, the use of AT (Bowlby, 1969) was found to be an important aspect of relational work for both TCWs and TFCs. TFC approaches were also informed by SLT (Bandura, 1977). Both theories supported new learning being facilitated for the LAC in the context of a close relationship and organisational culture. Furthermore, drawing on SLT within TCs may be beneficial.

Theoretical understandings in relation to mentalisation were highlighted as underpinning the relational approach. The empirical evidence suggested that TCWs were mentalising about the children and responding to them reflectively, despite the emotive context. This was supported by studies using the model of 'mindful' parenting. In this approach, parents exercised choice in responding to experience, thus providing an alternative to engaging in habitual, or 'automatic', cognitive and behavioural reactions to experiences (Duncan, Coatsworth & Greenberg, 2009).

In terms of the second aim regarding TCWs implementing theories in practice, the theoretical literature suggested that working in ways to foster secure attachments with LAC could be beneficial. The empirical research suggested that TCWs facilitate relational work through the development of secure attachments with the children, clear communication between carers, and maintenance of their own emotional resilience. Within the TFC literature, facilitating positive relationships with the children was found to reduce difficult behaviours.

With regard to the third aim, all carers reported supervision to be a source of support. Across the majority of TCW papers, the use of supervision in processing unconscious dynamics and increasing self-awareness was an important factor in facilitating relational work. Arguably, supervision took on differing forms for the

different groups of carers. TFC supervision appeared to provide support and advice on implementing the specific techniques of the intervention whereas for TCWs, the supervision was reported to be more process orientated (e.g. unconscious processes). Protective factors included a supportive staff culture for TCWs, which could be linked to TFCs' experiences of mutual support in a group setting (Bywater, et al., 2011; Holmes & Silver, 2010).

With respect to the fourth review question regarding the emotional wellbeing of carers, intense emotional experiences were reported for both carer groups. All carers were described as working in volatile and unpredictable settings. The need for self-awareness and reflection on TCWs' past relationships and experiences was highlighted as necessary in allowing them to depersonalise negative behaviours and acknowledge how their life experiences could influence their initial, unprocessed reactions in emotive situations.

Overall, when compared to the TFC literature, the TCW research appeared to place more emphasis on unconscious processes. Additionally, a divergence was highlighted between the roles of TFC and TCW. TFCs tended to work with LAC who were able to develop attachments and manage home environments within the supported and supervised setting of specialist foster care. TCWs typically worked with children whose development has been so disrupted that they could not be sustained in such a care setting.

Fundamental differences in the placements should also be noted. TFCs were the sole providers of care for the LAC placed with them whilst TCWs could enter the TC and then leave to return to their own homes. The impact this may have on the relational elements of caring for LAC, and the impact on the emotional wellbeing of the carers, has not been discussed in the literature to date.

Summary of limitations

The reviewed papers provide an insight into the role of TCWs and TFCs. Despite all studies describing the importance of TCW-child attachments, only one study (Moses, 2000) directly explored how TCWs facilitate such relationships. The majority of articles provided anecdotal evidence and the data analysis methods in research studies often lacked detail, limiting the potential to replicate findings. The range of countries in which some studies took place limits generalisabilty to a United Kingdom population. Moreover, there was a paucity of studies employing quantitative research designs or control groups. Given that much of the research took the form of practice-based evidence, this is unsurprising. More rigorous research designs may facilitate the capacity to control for possible extraneous variables. Additionally, only three papers used standardised measures (Bywater et al., 2011; Holmes & Silver, 2010; Timmer et al., 2006b) and only two incorporated a follow-up (Bywater et al., 2011; McNeil et al., 2005).

Overall, limitations of the reviewed papers rendered conclusions regarding the role of TCWs and TFCs tentative. Nevertheless, the literature represents the beginning of an evidence-base.

Future directions

There is a need for larger, more rigorous studies detailing the roles of TCWs and TFCs. Future studies could adopt established qualitative methods in order to gain a greater insight into the role of TCWs and TFCs and the implications of their relational work. In reviewing the literature, similarities were evident between the roles of TCWs and TFCs. However, distinctions were identified and future research may benefit from exploring these roles separately.

Qualitative studies seeking to gain a richer understanding into how TCWs maintain the capacity to hold the children in mind and how they develop and sustain the capacity to work in psychologically minded ways with LAC, would increase psychological understanding of relational work. The review also suggests that self-reflection, (e.g. TCWs'/TFCs' own attachment histories) should also be investigated further. Findings could inform professionals about the nature of the work and the potential benefits, and may also help identify relevant staff training and support needs.

NICE (2010) guidance recommends that research into residential care should be undertaken. Therefore, future studies could use this review to inform outcome studies seeking to build a body of evidence investigating the value of TCWs. Given the approaches used by TCWs/TFCs, the psychological and social characteristics of children in different residential placements could be considered in order to further inform the professional decision making process regarding where to place a child.

The existing research, despite its limitations, has highlighted important implications and protective factors for carers undertaking relational work with LAC. Further research is needed to explore these issues in more depth as well as to extend the evidence-base in this area.

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ELEANOR G. FERRIS BSc Hons

WORKING RELATIONALLY WITH LOOKED AFTER CHILDREN: THE ROLE OF RESIDENTIAL THERAPEUTIC CARERS

Section B: Experiences of therapeutic residential carers working relationally with Looked After Children.

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Abstract

Objectives. Some theoretical and descriptive accounts of therapeutic childcare suggest that the most vulnerable group of Looked After Children (LAC) benefit from living within therapeutic communities. This study aimed to explore how therapeutic care workers (TCWs) experience their role and their perceptions of the potential benefits for LAC.

Design. A qualitative design using Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009) was applied.

Methods. Nine TCWs currently working in one of two therapeutic communities were interviewed.

Results. Five master themes were identified: 'Therapeutic group living'; 'Importance of carer-child relationships'; 'Working with the unconscious'; 'Personal meaning of professional role', and 'Children's progress'. Participants considered that forums for reflection were crucial to their ability to think clearly and analytically about the children, and utilised psychodynamic concepts to gain insight into the children's inner worlds. TCWs' increased self-awareness was central to this process. Participants also reported experiencing their role as emotionally challenging. One focus of reflection was on the small steps of progress the children were perceived to achieve.

Conclusions. Overall, the findings suggested a synergy between relevant theory, descriptive accounts of therapeutic childcare, and TCWs' perceptions of their role. New information regarding the personal investment of TCWs and internalisation of the framework of practice was identified. Further research is needed to extend the evidence-base. The clinical implications of the findings are discussed.

Keywords. Looked After Children; therapeutic communities; attachment; relational approaches; therapeutic care workers.

Introduction

Looked After Children in Residential Care

In 2012, 67,050 children were removed into local authority care, usually following harm or neglect (Department for Education; DfE, 2012a). National Institute of Clinical Excellence guidelines (NICE; Department of Health [DH], 2010) have highlighted that Looked After Children (LAC) in residential care often have particularly complex psychological needs. These are often characterised by attachment difficulties, educational difficulties, relationship insecurity, sexualised behaviour, trauma-related anxiety, conduct problems, and hyperactivity (Cousins, Taggart & Milner, 2010; Ford, Vostanis, Meltzer & Goodman, 2007; Sinclair, Baker, Lee & Gibbs, 2007; Sweeney, 2008). The most needy LAC have often experienced multiple placements which have broken down due to foster carers feeling unprepared for, or unable to manage the intensity of the children's emotional and behavioural needs (Craven & Lee, 2006; Golding, 2010; Kohlstaedt, 2010; McQueen, Itzin, Kennedy, Sinason & Maxted, 2009). These children are sometimes placed in therapeutic communities (TCs; DH, 2010; Kohlstaedt, 2010; McQueen et al., 2009).

The Role of Therapeutic Communities for LAC

TCs are residential placements where children live and attend school. TCs constitute a therapeutic milieu, which is a facilitated 'total environment' for children and staff (Collie, 2002; McQueen et al., 2009). Therapeutic care workers (TCWs) are supported to think in a psychologically minded way, receive ongoing training and supervision, and have forums where issues associated with working at a deep emotional level with the children can be continuously contained and processed (Collie, 2002; McLellan, 2010; Tomlinson, 2005). The theoretical underpinnings of this approach will now be discussed.

Theoretical Frameworks of Therapeutic Communities

TCs purport to be underpinned by theoretical frameworks that are drawn from an extensive evidence-base. Three key theories informing TCs are attachment (Bowlby, 1969), mentalisation (Fonagy, Gerely, Jurist & Target, 2002) and resilience (Luthar, Cicchetti & Becker, 2000). These theories have been found to be beneficial for understanding and exploring the therapeutic alliance in psychotherapy (e.g. Adshead & Fonagy 2012; Holmes, 2011; Smith, Msetfi & Golding, 2010) and their use as an intervention for children with emotional and behavioural needs has been explored (Booth & Jernberg, 2010; Golding, 2003).

Attachment. Attachment theory explains how the nature of early relationships can impact on later social, emotional and cognitive development (Bowlby, 1969). Within a secure attachment, the carer's ability to mentalise and be attuned to the infant is said to facilitate the infant`s capacity for emotional self-regulation (Fonagy & Bateman, 2010; Schore, 2003).

LAC requiring TCs often present with 'disorganised' attachment styles and behaviours (Atwool, 2006; Main & Solomon, 1990; Van Ijzendoorn, Schuengel & Bakermans-Kranenburg, 1999). Due to a lack of, or disruption to, early attunement between the infant and primary carer, the child subsequently has little or no opportunity to experience sensitive reflection on their own mental state from the care-giver, resulting in impaired mentalisation skills (Lyons-Ruth & Jacobvitz, 1999). Instead, it is hypothesised that the child will internalise the volatile emotional states of the primary caregiver, which are likely to evoke fear (Craven & Lee, 2006; Fonagy et al., 2002; Holmes, 2005). Without early intervention, it is suggested that individuals

with this disorganised attachment may later develop borderline personality disorder (Fonagy & Luyten, 2011), experience increased anger, aggression and subsequent conduct disorder (Kochanska, 2001), and low resilience to life's challenges (Fonagy & Luyten, 2011).

Mentalisation. Mentalising is a form of imaginative mental activity; namely, perceiving and interpreting human behaviour in terms of intentional mental states, for example, needs, desires, feelings, beliefs, goals, purposes and reasons (Fonagy, et al., 2002). It is argued that the mentalising, psychological sense of self is rooted in the attribution of mental states, and that this capacity emerges through interaction with the caregiver, in the context of a secure relationship, via a process of contingent mirroring (Fonagy et al., 2002). Foster carers` ability to mentalise about children's behaviour has been considered pivotal in maintaining placements (Ironside, 2012).

Resilience. Resilience is defined as positive adaptation in circumstances where personal, familial or environmental difficulties could impair an individual's cognitive or functional abilities (Garmezy 1984; Luthar, 2005; Maston & Coatsworth, 1998; Rutter 1999).

Research into the protective factors associated with resilience, along with attachment theory, provides a multi-model framework in which TCWs aim to reduce risk and promote resilience within children (Bostock, 2004; Gilligan, 2009). Protective factors are thought to apply to three main areas of influence, the physical and emotional qualities and traits of the child, the family context and the social environment (Emery & Forehand, 1994; Grotberg, 1997; Luthar, 2005).

It is argued that by facilitating reparative secure attachments with children, TCWs may be able to offer alternative experiences where children can internalise positive and containing emotional states, thus increasing their ability to mentalise (Atwool, 2006; Dockar-Drysdale, 1990; Lieberman, 2003).

TCWs

It has been recognised that the assessment and treatment of children who have been neglected and/or harmed is complex and can be emotionally disturbing (Collie, 2008; McQueen et al., 2009). However, there is a dearth of literature investigating the impact of the role of carers implementing relational, residential interventions.

A qualitative study (Moses, 2000) examined carers' (n = 25) styles of engaging adolescent clients, with a focus on staff practice that facilitated a treatment context conducive to healthier client attachments. Carers demonstrated high expectations regarding their role: they sought to gain insight into children's inner worlds, attempted to attribute meaning to difficult behaviour, and needed to acknowledge that their own life experiences could act as barriers to relationships.

Carter (2011) interviewed nine residents living in a TC where carers were encouraged to develop their emotional capacity in order to relate to the children. Residents described an increased ability to relate well to others and attributed this to feeling 'wanted' by staff, a sense of belonging and feeling understood.

Seven case studies (Cant, 2002; Collie, 1996; Farragher & Yanosy, 2005; Kohlstatedt, 2010; Tolmacz, 2003; Tziotziou et al., 2006; Whitwell, 1998) focused on outcomes for children, but discussed implications for TCWs. Collectively, findings suggested that the role of TCWs incorporated both personal and professional aspects involved in acknowledging and working with unconscious dynamics. This indicated

that TCWs are required to be reflective, increase their self-awareness and remain resilient.

The theoretical, descriptive stance of most papers focusing on TCs limited the reliability and validity of findings. Furthermore, studies lacked comparative or control groups and longitudinal follow-ups. Additionally, the qualitative studies did not clarify the type of methodology used in analysis.

Summary

NICE guidelines for LAC (DH, 2010) have described children in residential care as the most vulnerable and traumatised individuals in the looked-after population. The literature reviewed above reporting on TCs suggests that a relational therapeutic approach with these children is necessary in order to repair the emotional damage of their traumatic life histories (Kohlstatedt, 2010).

Aims

There is a dearth of literature exploring the experiences of the 'front line' staff whose jobs are to work relationally and therapeutically with LAC. This study aimed to gain an understanding of the factors facilitate this relational work. The study aimed increase understanding about how TCWs develop and sustain the capacity to think about the children they work with, and on this basis, work with them in psychologically minded ways. It also aimed to further understanding about the direct impact of this work on TCWs' emotional wellbeing. Furthermore, it aimed to further understanding as to how TCWs perceive the effect of this work on LAC. Overall, it was intended that this study would develop psychological knowledge of relational work and the impact of this on TCWs and LAC.

The complex interpersonal and reflective experiences purported to be involved in undertaking relational work were considered to be most usefully explored using in-depth interviews and qualitative analysis (Elliot, Fishcer & Rennie, 1999).

Research questions. The four research questions were:

1. What are TCWs' perceptions of facilitating therapeutic, relational work with LAC in therapeutic residential care?
2. What are TCWs' experiences of the impact of their work on their own psychological wellbeing?
3. What do TCWs see as factors that enable them to develop and maintain the necessary resilience to cope with the emotional demands of the role?
4. What are TCWs' experiences of potential change in the children following a TC intervention?

Method

Interpretive Phenomenological Analysis (IPA) was chosen because it examines how individuals reflect on their views and experiences and the meaning they give to such experiences (Smith, Flowers & Larkin, 2009). IPA allowed TCWs to give a subjective account of their experiences in order to initially develop our understanding in this area, in contrast to, for example, grounded theory (Glaser & Strauss, 1967) which would also seek to generate theory regarding the TCW role.

IPA recognises that the personal preconceptions and individual reflections of the researcher lead to an 'interpretative' account of the data (Smith et al., 2009). This study was undertaken by a clinical psychology trainee in her second and third years of

training. She had previously worked as a TCW in two separate TCs, and had an interest in the advantages and challenges of therapeutic residential childcare for staff and children.

The Communities

Internet searches were carried out to identify therapeutic units within the UK. Five therapeutic units were approached and directors of two communities responded. Both communities comprised therapeutic children's homes where children lived in small units in groups of four to eight, with an independent school and a training and consultancy service. Children were aged between four and 18 years. One community was privately owned and the children lived there 52 weeks a year. The other was a not-for-profit organisation, where the children lived during term-time and resided with foster carers or family during school holidays. Children living in the homes were either accommodated by their local authority or subject to a full care order.

Both communities aimed to provide specialised individual programmes of therapeutic care and education in a 'family-like' context, to help children reach a more integrated level of personality functioning. Placements were offered to children who displayed high levels of disturbed behaviour and had difficulty containing or controlling their feelings.

Participants

In accordance with IPA guidelines (Smith et al., 2009), a small homogenous sample was recruited to examine convergence and divergence within the transcripts.

Telephone contact was made to the director of each community. An information sheet (Appendix C) detailing the purpose and aims of the study were sent to all TCWs within the community who met inclusion criteria. Inclusion criteria consisted of TCWs who spoke fluent English and those who had worked within the communities for a minimum of six months, to ensure familiarity with their role. Fourteen individuals expressed interest in participating in the study. Nine participants were chosen with a range of years of experience and job roles. Five participants from one community and four from the other attended a meeting where informed consent was obtained (Appendix D). The directors notified those without six months experience that they were not chosen to participate. Participants were between 25 and 50 years of age (Mean = 35.2, Median = 37, SD = 8.1). They had between nine months and 11 years of experience within their roles (Mean = 4.6 Median = 4, SD = 3.4). Individual and demographic characteristics of participants are displayed in Table 1.

Interviews

IPA studies aim to gather a rich, detailed, first person account of individuals' experiences (Smith et al., 2009). The semi-structured interview schedule (Appendix E) was developed in accordance with the research questions. Issues for TCWs explored in conceptual papers (e.g. Cross, 2010; McLellan, 2010), case studies (e.g. Kohlstatedt, 2010) and carer interview studies (e.g. Carter, 2010) were considered. Consultation with research supervisors who were both experienced in working with

Table 1

Individual and demographic characteristics

Gender	Age	Ethnic background	Job title	Years of working as	Undertaken training in	Age group working with

				a therapeutic care worker	therapeutic childcare	
Female	27	White British	Senior therapeutic care worker	5 years	Yes	13-18 years
Female	39	White British	Senior therapeutic care worker	11 years	Yes	9-12 years
Female	36	Black British	Senior therapeutic care worker	6 years	Yes	6-13 years
Female	40	White British	Senior therapeutic care worker	1 year	Yes	6-14 years
Female	50	White British	Housekeeper	2 years	Yes	8-14 years
Male	25	White British	Therapeutic care worker	9 months	In training	11-16 years
Male	26	White British	Therapeutic care worker	3 years	Yes	7-14 years
Male	37	White British	Therapeutic care worker	4 years	Yes	5-13 years
Male	37	White British	Deputy house manager	8 years	Yes	5-12 years

LAC and the carers of LAC was also undertaken. The questions and prompts were structured according to IPA guidelines (Smith et al., 2009). A pilot interview was conducted. Following participant feedback and reflection on the interview by the researcher, the schedule was deemed appropriate and was not adapted further. The questions aimed to explore TCWs perceptions about the intervention factors considered important, the impact of the work on their psychological wellbeing, what helped them cope, and how they experienced the intervention affecting the children.

Interviews were conducted within eight weeks of the initial meeting with staff. All interviews took place in work settings and lasted between 42 and 87 minutes. Audio recordings were transcribed by the researcher for analysis. Confidentiality was

discussed and consent forms were completed (Appendix D). While it was offered, no participants felt the need to undertake a debriefing session following the interviews, nor did they elect to receive a copy of their transcript. All participants chose to receive a summary of the findings (Appendix F).

Ethical Considerations

Ethical approval was obtained from the Canterbury Christ Church University's Ethics Committee (Appendix G). Participants were assured that identifiable information would be removed before data analysis, and that participation in the study was not expected as part of their job role, nor would it affect their position at work in any way. The directors of both communities requested that the organisations' identities were made available when this research is submitted for journal publication. The study was conducted according to the British Psychological Society code of ethics and conduct (2009).

Data Analysis

Data was analysed using IPA and the use of a 'double hermeneutic' (Smith et al., 2009), whereby the researcher sought to make sense of how carers gave meaning to their experiences. According to the guidance set out by Smith et al. (2009), the first four transcripts were read and re-read to heighten the researcher's familiarity with the data and initial comments were made (Appendix H). Initial emerging themes (Appendix I) were developed and connections between themes were noted and explored before analysing the next transcript. Following reading and re-reading the remaining transcripts, analysis focused on the key themes that had emerged in the first four transcripts. New emerging themes were then extracted across previous cases.

Themes were considered for similarities and differences across all cases. These were then summarised into master and sub-themes.

Quality Assurance

Criteria in assessing validity in qualitative studies were adhered to throughout this study (Bailey, White & Pain, 1999; Baxter and Eyles, 1997; Beck, 1993; Yardley, 2000). Criteria include ensuring sensitivity to context, ensuring and demonstrating researcher reflexivity, and transparency of methods. To ensure sensitivity to and familiarity with context, the researcher attended one community for a day in order to familiarise herself with the carers' working environment. This enabled consideration of the specific context in which the study was conducted. 'Commitment and rigour' (Yardley, 2000) was accounted for by following established IPA guidelines (Smith et al., 2009). Substantial parts of the analysis were cross-checked by both supervisors and a fellow trainee, who was uninvolved in the study but experienced in IPA, to ensure that the themes were grounded in the data.

Yardley (2000) highlights reflexivity as an important factor in qualitative analysis. Once the interview schedule was finalised, the researcher was interviewed by a fellow trainee about her preconceptions and experience of working as a TCW (Appendix J). A reflective journal was kept (Appendix K) and regular discussions with supervisors were undertaken.

Results

Analysis revealed five master themes and 14 sub-themes, as displayed in Table 2. These are considered in the following sections using verbatim extracts.

Themes were derived from initial codes (Appendix I). See Appendix L for further example quotations.

To ensure confidentiality, participants were given pseudonyms and identifying information was removed. Where information has been omitted, square brackets are used.

The Therapeutic Aspect of Group Living

This master theme indicates that for the majority of participants, being part of a group which places importance on communication was central to their work within the community.

Open and honest reflection. Most participants (6/8) described forums for reflection being incorporated into everyday practice. These included group supervision and process meetings, individual supervision, children's group meetings, de-briefing sessions, and informal discussions between staff or children. Five participants expressed feelings of relief and dependence associated with reflecting as part of the group process, suggesting that they found the forums a source of support:
John: '*It's one of them places where I feel that if I'm having a mad five minutes I can sit down and say 'help.''*

Luke: '*The reflection side is very important because if you just take it as it is, then you're not going to find an ending to it. It will still loom in the back.'*

Table 2: Master themes and sub themes

Master themes	Sub themes	Number of participants for whom

		the theme occurred (Maximum n = 9)
The therapeutic aspect of group living	Open and honest reflection	6
	Individuals are part of a group	8
The importance of carer-child relationships	Therapeutic work occurs in the context of a secure attachment	9
	The importance of consistency and clear boundaries	8
Working with the unconscious	Working with psychodynamic concepts and attachment theory	8
	Reflexivity	7
	Behaviour understood as a communication	9
	The inner world of the children	8
Personal meaning of professional role	The value of, and confidence in, the role	8
	Emotional impact of the role	9
	Investment of the self	8
Children's progress	Progress is individualised	9
	Building resilience	9
	Discovery of a sense of self	6

Shareese: '*You have to check in to honesty mode [] there is something quite relieving about that. It makes it quite relaxing.'*

One participant shared uncomfortable, difficult feelings associated with taking part in such forums:

Luke: *'You sort of lay yourself very open to your raw feelings and what's going on for you and it can be quite difficult to do that'.*

Three participants experienced the forums as intrinsic and necessary to their work, conceptualising them as a way of making sense of their experiences:
Ben: *'Without that reflection, on the behaviours and the projected feelings, people would just leave.'*

Helen: *'There's [] a big element of reparation, making it better or thinking about it and learning from our mistakes.'*

Individuals are part of a group. Most participants (8/9) talked about their function as part of a group. Participants seemed to experience a sense of belonging and trust within their teams, which seemed pivotal to carrying out their role.

Helen: *'You don't need to feel disempowered or stressed that someone has just come and taken over a situation.'*

Kevin: *'When I go off on shift they[2] don't fall apart, other people can help them, can respond to their needs.'*

[2] 'They' refers to the children

Janine: '*We are always looking out for each other and I think if you didn't have that, if you were just working in isolation, there is no way you could do it.'*

Two participants talked about the children being part of a group. Carers seemed to experience this as providing children with an opportunity to internalise a sense of belonging, and responsibility for others.

Karen: '*It obviously teaches them respect for each other.'*

Alesha*: 'When they smash something up - they've got to put something nice back in to the house - that's what you do [] it's everybody's home.'*

The Importance Of Carer-Child Relationships

This master theme depicts how relational aspects of the role were at the forefront of the carers' experiences.

Therapeutic work occurs in the context of a secure attachment. This theme captured the centrality of how developing secure relationships facilitated therapeutic work with the children. It was striking that all participants described how their relationships enabled the child to build trust and learn an alternative way of relating to people. For example:

Luke: '*You have almost got to sort of adopt the role of the primary care-giver and give them that sort of parental nurture that they never really had before.'*

Kevin: *'They're able to securely attach to me [], that safety net then that allows them to do what they would have done if the experiences hadn't been there as a child that were traumatic.'*

Participants described how the context of secure relationships offered the children an opportunity to express their feelings, in order for them to be reflected back in a more manageable form.

John: *'...and my role [] is to try and build a relationship so she can transfer some of her feelings and I can reflect them back.'*

Alesha: *'He tells me he hates me all the time. But that's brilliant because he can trust me enough to say that he hates me.'*

The importance of consistency and clear boundaries. Providing the children with a sense of predictability that differed from the context of their previous relationships appeared to be viewed as important for eight participants, and seemed intrinsic to facilitating secure attachments. For example:

John: *'You can have some control over their lives, which obviously they have never had before.'*

Janine*: 'Sticking to the boundaries and the structures and routines that help them feel safe.'*

One participant reflected on the struggle of being consistent with boundaries, when faced with resistance from the children.

Janine: '*The constant battle around rules and boundaries, yeah, I mean that can be quite tough. Especially when you first start.'*

Working With The Unconscious

This master-theme reflects how carers attended to unconscious processes. Sometimes this involved participants referring to specific psychodynamic concepts. Other descriptions included the capacity to be reflective and consider the meanings beneath behaviours, despite working in highly emotive situations.

Working with psychodynamic concepts and attachment theory. Despite some carers having less than one year's experience in their role, participants (8/9) described the incorporation of concepts such as projection, transference, and counter-transference, and the utilisation of attachment theory to inform their work. Responses suggested that carers had internalised such concepts and were using them as therapeutic tools and as a way to personally cope with challenging and emotive interactions. For example:

John: '*I just got completely caught up in her panic []. And my manager sat me down and went, 'hello … this is projection!' and I was like, 'OK.' And I had a few weeks to think about it and I was like, OK I kind of get projection now, before it was like a word, but now yeah….'*

Alesha: *'The transference. It's bizarre. I never knew anything like it in my life. (laughs). [] I can be in a room with her and just feel like bursting into tears and yet I come into work happy as larry. So it's trying to think "this isn't me, this is her feelings."'*

Participants internalisation of psychodynamic concepts seemed evident in that they referred to them without naming the concept or theory.

Shareeze: *'It's addressing those things because you have to look at them and go, "what is it about me that that child has picked up on" because a lot of it is non-verbal communication and children pick up on things that they know will get under your skin.'*

Alesha: *'She can be angry and I'll feel it and I'll say, "you're angry - I can feel you're angry."'*

Two participants expressed relief at understanding unconscious processes, as it enabled them to separate their own feelings from those of the children.

Janine: *'I remember my first year, thinking "what is the matter with me?" [] when you start to understand and process it, you can start to think "ok, what's mine and what's not," then you can kind of shed it off a bit and yeah, it's just a relief I think.'*

John: *'I just went home feeling like um yeah just (signalled hands on head). As soon as I could name it, I could pick it apart.'*

Reflexivity. Participants (7/9) described being reflexive and thinking about the hidden meaning of the children's behaviour as vital to their role, often needing to do so during emotive situations.

John: *'Sometimes it's hard to try and keep all that in your head when something's going wrong but I do try.'*

Alesha: *'I can be playing a game with her, but inside my head I'll be thinking, "God, this is really bad, she's feeling really bad."'*

For some, length of experience appeared to increase ability to reflect in the moment:

Shareese: *'Having that headspace takes you away from the argument with the kids. A reflective space. [] The longer you work here, the more you can do that in your head when you're actually there.'*

Janine: *'You can't rely on just how you react, you need to think.'*

Behaviour understood as a communication. All participants seemed to think that reflecting on the child's inner world supported them to find meaning behind the children's interactions and behaviours:

John: *'Whatever they're doing. Um trying to link that back to where they're feeling, try and help them deal with it.'*

Karen: '*You have to shake yourself off and think through what it means for the children.'*

Reflecting on the children`s internal worlds seemed to help the TCWs understand behaviour as communication, sometimes linked to their past experiences:

Helen: *It's thinking, "What does that mean? What's going on there? You have peed out of your window [] what are you trying to let us know?"'*

Luke: '*We've got a couple of kids and you can see quite clearly how much they act out their past in the sense of the violence they show, towards people.'*

The inner-world of the children. Participants (8/9) reflected on some of the experiences of the children, which they experienced through the children`s unconscious and conscious channels. There was a sense that this promoted a strong connection with the children.

John: '*She's managed to verbalise with me, [] anyone that gets close to her, [] she feels is gonna abuse her.'*

Alesha: '*She was seeing him. Her abuser. Yeah, definitely, you could feel it.'*

Some participants recognised that the children`s past continued to influence their internal world as manifested in their behaviour and how they related to those around them, despite now being in a safe environment.

Helen: '*We've got another little girl who was very badly sexually abused by her mum [] when she first came, her way of trying to interact would be to say 'will you lick me?' and pulling her knickers down.'*

Participants also had a strong sense of the emotions evoked within the children that seemed hard to escape:

Janine: '*Anger, sadness is huge. The sense of hopelessness.'*

Ben: '*Living in that constant fear.'*

Personal Meaning of Professional Role

This master theme illustrates that participants conceptualised their role as involving an intricate combination of experiences. This included widening knowledge, belief in their approach, and balancing personal and professional life, together with a range positive and negative emotional experiences.

The value and confidence in the role. Most (8/9) participants expressed feelings of enthusiasm and hope when describing their work. This seemed due to their increased confidence in their approach, which they attributed to training and support structures. For example:

Alesha: '*I love process meetings [] a time to offload a little bit.'*

Shareese: '*There is that underlying passion for the kids.'*

Janine: '*I feel really lucky.'*

Witnessing positive changes in children seemed to increase their confidence in their role:

Ben: '*Its nice when old children*[3] *come [], that really gives you a sense that we are doing some good.'*

Kevin: '*I've seen it work, I know it works, I trust that it will work, I also know it's got its limitations and so I don't think it's the holy grail.'*

Emotional impact of the role. Participants expressed a range of emotions which they experienced as part of their role, potentially reflecting the emotional states of the children. One person reported experiencing feelings of worry when it was time for the child to leave the home:

John: '*I sometimes worry about them when they hit 18*[4]*.'*

[3] 'Old children' refers to ex-residents of the community.
[4] Placements within the community end when children reach eighteen years of age.

Others also expressed feelings of sadness, which could also reflect the feelings of the children:

Karen: '*I felt upset, as the children seemed upset. And it felt, unfair and bad.'*

Helen: '*I felt the brunt of those nine children's feelings. It was hard. A very grim day.'*

Anger towards the children, their absent parents and situations in general was also a common feeling :

Alesha: '*I felt really angry at him; he was shouting, "You're fucking abusing me."'*

Ben: '*Sometimes you feel angry, upset, judgemental towards parents.'*

Shareese: '*I felt anger, but not towards him - anger that he didn't know any different. It was just kind of gut-wrenching.'*

Feelings of being powerless, frightened or threatened were also experienced:

Alesha: '*I wasn't scared about him coming in the door; I was scared for her and for how she was feeling. It was awful, it was really bad.'*

Luke: '*The first time you see the children attacking and spitting and urinating through doors, it's just like "my god, what's happening."'*

When reflecting on the difficult feelings often aroused in the work, three participants shared that staff need to be able to withstand the children`s projections. For example:

Luke: '*Resilience in the staff- being able to withstand what's being put to you and what you're getting from these children - the violent reactions.'*

Helen: '*So people have to come with a certain level of resilience and I think they have to be willing to use the support structures.'*

In contrast, many participants also associated more positive feelings with their work such as enjoyment, love, pride and hope.

John: '*I can reel off hours of all the great fun I've had.'*

Luke: '*The violence having almost stopped completely, it just makes you feel very proud.'*

Janine: '*It's just that hope and [] admiration as well - for the children - for me I think it can bring up maternal feelings [] very loving feelings.'*

Many participants reflected on the range of feelings evoked within the role, some of them ambiguous and quickly changing:

Karen: '*It's like a rollercoaster.'*

The word "rollercoaster" evokes a sense of uncontrollability and rapid changes between positive and negative emotions, as reflected by another participant: *'It's very difficult at times. Ultimately extremely rewarding. There's [sic] a lot of highs and lows in the job I think.'(Luke).*

Despite this, there was a sense that the rewarding aspects of the role balanced out the challenges:

Janine: '*Emotionally, physically, it can be really tough. Um, but It's [] the best job I've ever done.'*

Investment of the self. There was a sense from the majority (8/9) of participants that it was necessary for them to invest and reflect on parts of themselves, their personalities and their values because the use of self constituted an important 'therapeutic tool'. Three participants described this through their understanding of their role as 'more than just a job'. For example:

Alesha: '*If you don't care about these kids and you just want your shift to finish, then you shouldn't be in that line of work.'*

Kevin*: 'I'll [] turn up for their review regardless of whether I'm meant to be at work or not, um that I'll think about them enough to give them a phone call during the holidays.'*

Participants seemed to be willing to share their real selves with children and colleagues therefore demonstrating how the job requires a significant degree of personal investment and authenticity.

John: *'If I turned up and didn't invest myself, they would know I was talking shit and weren't [sic] there for them.'*

Alesha: *'I just think it's really important to be real.'*

Ben: '*You bring yourself. I bring me as a person.'*

The following quote seems to demonstrate that such authenticity consists of staff sharing their real selves and not their defended selves.

Janine: '*You have to maintain your professional boundaries but you can't expect them to give parts of themselves and you not to give parts of yourself.'*

There was also reflection on carers developing their own self-awareness and personal growth.

John: *'Until I started doing this work I wasn't particularly in touch with my feelings. [] now I have to be aware of them. I think I've grown a bit as a person for doing so.'*

Ben: *'It made me understand that I was quite a rigid person. Very much black and white.'*

Shareese: '*A lot of it is based on your own childhood.'*

Children's Progress

This master theme depicted how participants viewed children making progress throughout their placements. Common themes reflected how resilience and self-esteem was seen to increase, together with children developing an identity and sense of self. Initially, the individuality of each child's journey was considered.

Progress is individual. There was a sense that the children's progress was thought about in small, individual, and gradual steps. For example:

Helen: '*The girl who came and wouldn't talk was talking before she left. The boy who could only communicate with a big punch to the belly was able to downgrade it to a nip.'*

Janine: '*It's different for every child.'*

Shareese: '*It can take all of three years to get one child to look at another child and say sorry and mean it genuinely.'*

Alesha: '*He's been here three years, and he's only just started to talk about his feelings.'*

Building resilience. All participants seemed to link the children's progress with their increasing confidence, undertaking new challenges, and gaining a sense of

achievement. Participants seemed to provide the children with the security and encouragement needed to progress:

John: '*Through your support, they take on new experiences, take the risk and then feel good afterwards.'*

Luke: '*Getting all that positivity back into them and making them feel like they are achieving something.'*

Ben: '*I think children learn, their confidence grows in this environment.'*

Participants seemed to hope to prepare the children for the 'outside world', viewing this as an important and necessary process in sustaining their progress.

Alesha: '*It's about getting them ready as much as you can.'*

Shareese: '*It helps them prepare for what life is like []. It's teaching them to problem solve rather telling them what to do. There's an element of resilience that comes with that.'*

Janine: '*We provide them with tools to deal with life in general.'*

Kevin: '*It's hopefully a learning experience and one that prepares them for the real world rather than a positive cotton- wool one.'*

Discovery of a sense of self. Most participants (6/9) reported providing experiences where children seemed to feel safe enough to explore their own interests and develop their own values, thus developing a sense of self.

Kevin: '*I think we are very, very good at allowing children the space to explore who they are.'*

Shareese: '*There is a lot of copying of behaviour - both negative and positive [] so what we try and do is help them to find who they are.'*

Helen: '*He can sense that whatever he suggests or feels is worthy so he doesn't have to be into other people's hobbies.'*

Ben: '*We aim to do [sic] is give the child the building blocks to come to terms with what has happened [] to understand it's not their fault and also not to dismiss it, it's part of them now, it's part of who they are.'*

Discussion

This study aimed to understand how TCWs facilitate relational work with LAC, the impact of this work on their psychological wellbeing, the factors involved in maintaining their resilience, and their perceived outcomes for the children of this approach. The findings are considered in relation to existing theory and literature. Consideration is given to clinical implications, methodological issues, study limitations, and areas for future research.

What are TCWs' perceptions of facilitating therapeutic, relational work with LAC in therapeutic residential care?

Research question one aimed to gain an understanding of TCWs' perceptions of facilitating relational work. This understanding was reflected in the following themes: '*Importance of carer-child relationships'*; '*Personal meaning of professional role';* and, '*Working with the unconscious'*. Many participants described a belief that secure carer-child relationships enabled children to build trust and learn alternative ways of relating to people. This finding was consistent with Moses' (2000) study, which found secure attachments between carers and LAC as mediating the relational approach. Participants drew upon psychodynamic concepts to inform their work (Bateman & Holmes, 1995; Tomlinson, 2005; Winnicott, 1986), supporting previous theoretical and descriptive accounts of residential therapeutic childcare (Collie, 2008; Lieberman, 2003; McLellan, 2010). Findings suggested that participants had internalised these concepts and applied the theory to their everyday practice. This extended to participants relatively new in role, although with six months relevant experience. Participants described achieving this by using their emotions to gain insight into the children`s inner worlds. It is possible that their emotional states reflected the emotional experiences of the children, thus drawing a connection between the themes '*Personal meaning of professional role'* and '*Working with the unconscious'*.

What are TCWs' experiences of the impact of their work on their psychological wellbeing?

The theme '*Personal meaning of professional role'* addressed the second question by encapsulating how working as a TCW could include both challenging and

rewarding experiences, thus evoking a range of emotions. These findings illuminated conceptual literature detailing the potentially complex emotional demands of this work (McQueen et al., 2009). TCWs conveyed that the job required a significant degree of personal investment and authenticity, thereby suggesting that TCWs function as a 'therapeutic tool' in engaging with the children. Participants acknowledged that there was a personal cost to this. On difficult days, the investment of self and emotional connection to the work, seemingly left TCWs feeling devalued.

Self-development was considered necessary for the role. Some participants mentioned making connections to their own childhood and others described learning more about their personalities. These findings were consistent with previous literature focusing on how foster carers' previous attachments were connected to their parenting styles (Ballen, Bernier, Moss, Tarabulsy & St-Laurent, 2010; Caltabiano & Thorpe, 2007).

What do TCWs' see as factors that enable them to develop and maintain the necessary resilience to cope with the emotional demands of the role?

The themes '*Therapeutic group living'* and '*Working with the unconscious'* provided an understanding relevant to the third research question regarding what factors TCWs perceived as facilitating their resilience. Participants experienced their organisations as facilitating opportunities to reflect on practice, seek help, and have team-based support. Such structures have been described as vital in conceptual literature (McLellan, 2010). The current findings add to our understanding of the function of such structures. For participants, reflection seemed to mean that difficult experiences were transformed into more bearable understandings of the children. '*Working with the unconscious*' contributed towards effective therapeutic work by

providing insight into the inner world of the children and an understanding of unconscious processes at work. This provided relief for the TCWs. At times, it allowed TCWs to separate their feelings from those of the children, which helped them to process such material and maintain their emotional wellbeing and resilience. These are significant findings, given the amount of stress and emotionally challenging situations, which carers often face (McQueen et al., 2009). It could be construed that training on concepts such as projection, transference and counter-transference could be useful for the wider group of foster and residential carers.

What are TCWs' experiences of potential change in the children following a TC intervention?

In terms of the fourth research question, the themes '*Importance of carer-child relationships'* and '*Children's progress'* capture how TCWs experienced changes within the children during and following residential therapeutic intervention. As depicted within the '*Importance of carer-child relationships'* theme, participants conceptualised secure relationships as facilitating relational work, enabling them to mentalise about the children. Participants also reported that secure attachments facilitated the development of mentalising capacities within the children. Participants described children learning to verbalise feelings rather than enact them. This could be understood in the context of findings that mentalisation-based treatment approaches, which help individuals to self-regulate their emotions, are facilitated by secure, therapeutic relationships (Fearon et al., 2006; Fonagy & Bateman, 2010).

The theme, '*Children's progress'* captured how participants experienced the children making gradual progress throughout their placements. Resilience and self-esteem were perceived to increase, providing support for the theory that secure

attachment promote the development of resilience as one of the primary protective factors that buffer an individual against life challenges (Atwool, 2006; Luthar, 2005; Yates & Masten, 2004). Children were perceived to develop problem solving skills and increase an in confidence, reflecting research findings on promoting resilience (Atwool, 2006). Participants noted that, over time, the majority of children built an identity and 'sense of self.' Similar findings were highlighted in an empirical study (Carter, 2011) reporting on the experiences of children at a TC, who described increasing their ability to relate to others, a feeling of 'belonging', and building of identity.

Summary

The themes emerging in this study add to the existing literature by providing examples of direct experiences of TCWs who are attempting to put theory into practice in TCs. Findings illustrate how the emotional experiences of TCWs are contained and processed by the support structures that encompass therapeutic childcare. This study found that TCWs are encouraged and supported in increasing their self-awareness, including reflecting on how their early attachments affect their therapeutic relationships with children and other carers. Moreover, participants showed good fidelity to the analytic model. They illustrated how working with the unconscious, including attending to counter-transference, had been internalised due to living the model experientially. This study also highlighted examples of the gradual and idiosyncratic change, which LAC in TCs demonstrated.

Methodological Considerations: Strengths and Limitations

The use of qualitative research makes a useful contribution to the evidence-base

by exploring participants' experiences without being limited by concepts set out in self-report questionnaires. The use of IPA has illuminated the theory underpinning therapeutic childcare, as well as offering new insights into the role of TCWs, which warrants further investigation.

This study used a small, purposive sample of TCWs from two TCs, who were predominantly White British. This limits transferability to the wider population (Smith et al., 2009). As the sample was self-selected, there may have been particular reasons why TCWs volunteered to participate in the study, potentially indicating recruitment bias. For example, those with more confidence in their role or those who were more invested in the model may have been more likely to volunteer.

A further critique of IPA is that it is arguably limited to the reporting of conscious experiences and perceptions. Therefore, IPA may neglect the researcher's unconscious reactions to participants, their responses, and unconscious communications (Clark & Hoggett, 2009).

Given the researcher's interest in this area, it was important to ensure reflexivity and to acknowledge potential assumptions. Although attempts were made to be rigorous and transparent, IPA`s double hermeneutic means that the identified themes emerged through the researcher's interpretation. Given this, a number of quality checks were undertaken including an independent colleague and supervisor independently coding interviews and participant validation of findings (albeit with a limited response from two participants).

Clinical Implications

Findings highlight those aspects of TC which help TCWs to engage in offering

a therapeutic environment to children who are often difficult to engage and who can exhibit extremely challenging behaviours. The present study suggests that this approach is facilitated through working from a consistent model, which is carefully applied and supported by a well developed organisational structure and culture. It may be that any model that is coherent and delivered with a high level of integrity and commitment from professionals could produce promising outcomes (Bateman & Fonagy, 2000).

Although job satisfaction is potentially very high, the level of authenticity and dedication demanded by the work of TCWs brings challenges. The work is emotionally taxing, demanding high levels of self-reflection and awareness. The importance of an organisational culture supporting reflection and training on unconscious dynamics was highlighted. These are findings which occur in the context of existing literature and government policies highlighting the importance of staff training in attachment-based approaches when working with LAC (DH, 2010). It could be hypothesised that training incorporating similar content, structure and support as demonstrated in the participating communities could be beneficial for the wider LAC population.

Clinical psychologists (CPs) and other clinicians could offer consultation to support organisations, such as fostering agencies or other residential establishments, to enhance and support carers' personal and professional development. It would be important for psychology provision to focus on supporting carers in developing their self-awareness and to facilitate understanding of the unconscious dynamics involved in relational work.

Participants described children showing gradual and idiosyncratic indications of progress, which suggested that such changes may be too subtle to be recognised using

standardised outcome measures alone. Qualitative records in the form of detailed process notes, for example, seem to have a place in monitoring children's change throughout and post-placement. The use of sophisticated outcome measures (Gresham & Elliot, 2008), the reviewing of process as well as behaviour, and detailed clinical assessment of mentalising within the children (Luyten, Fonagy, Lowyck & Vermote, 2012) may be useful additions to routine practice.

Research Implications

This is the first rigorous qualitative study that has reported on the subjective experiences of TCWs. Future studies focusing on the qualities needed for residential therapeutic work with LAC and the emotional impact of this relational work should recruit specialist foster carers, carers from generic childrens' homes, social workers, and professionals working in care leaving teams, in order to triangulate findings and provide a comparison to the processes involved in therapeutic communities.

With regard to outcomes for the children, further studies utilising quantitative and qualitative methodologies are needed to compare outcomes of a range of establishments. Qualitative outcomes for children within TCs would complement quantitative measures due to the idiosyncratic ways in which the children seem to demonstrate change. Studies using projective techniques with young people, such as Story Stem approaches (e.g. Hodges, Steele, Hillman & Henderson, 2003; Steele et al., 2009) could provide useful insights into the children`s inner worlds. Quantitative studies applying standardised outcome measures, for example, mentalisation-based scales, are also needed to demonstrate the potential efficacy of TCs. TCs should be encouraged to publish the outcome measures they already collect in their routine practice.

The importance of self-awareness within TCWs has been acknowledged in descriptive accounts of therapeutic residential childcare (e.g. Farragher & Yanosy, 2005). Despite this, however, no studies to date have directly illustrated how TCWs are assisted to make connections as to how the dynamics apparent in their relationships with the children may be connected to their personal experiences of attachment.

Conclusion

The use of IPA has illuminated extant theory by providing examples of the lived experience of TCWs, demonstrating how they incorporate underpinning theory into their daily, clinical practice. Working within the context of secure attachments was experienced as intrinsic to their role. Considerable personal investment was involved in the role, including the need to increase self-awareness. Organisational structure and support systems were regarded as important factors for maintaining participant resilience and reflexivity. Change in the children was experienced as gradual and individual. These findings have important clinical implications in terms of the role of CPs and other professionals in supporting carers of LAC.

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ELEANOR G. FERRIS BSc Hons

WORKING RELATIONALLY WITH LOOKED AFTER CHILDREN: THE ROLE OF RESIDENTIAL THERAPEUTIC CARERS

Section C: Critical Appraisal

Word Count: 1999

A thesis submitted in partial fulfilment of the requirements of
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Doctor of Clinical Psychology

MARCH 2013

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Prior to starting clinical training, my experience of research comprised of a small-scale research project at undergraduate level and numerous service evaluations and audits whilst working as an Assistant Psychologist. While these experiences enabled understanding in managing and analysing quantitative data, I started training with minimal experience of qualitative methodologies.

I have developed many new skills throughout the research process including: identifying ideas and devising research questions that were feasible whilst completing the doctorate course; building relationships with my research supervisors and professionals from outside agencies; writing a research proposal; deciding how to recruit participants; and, selecting and utilising an appropriate methodology.

Reflecting on ethical issues and gaining ethical approval was a new experience for me. It was important to thinking through the potential ethical issues for participants (e.g. confidentiality, distress, perceived effects on TCWs positions at work) and I learned about the consultation process by asking a group of residential social workers for their views on my research idea (including the research questions and potential ethical issues). Consulting with my supervisors about managing these ethical issues was invaluable. I reassured directors of the therapeutic communities and participants about the protection of data confidentiality and ensured that they were aware of important issues regarding consent, the right to withdraw, and managing any distress that may arise due to participation. The Salomons ethics approval process

was rigorous, however, I feel that it is important to experience the NHS ethics process as part of my future practice as a clinical psychologist.

I developed new key skills through systematically analysing my data. This included: learning the benefits of transcribing the interviews myself; repeated reading and listening to audio recordings of interviews; and, developing, combining and modifying emerging themes. Writing up the research required complex thinking and planning with regards to the structure of each section, where it was necessary to select areas to further develop or summarise. For example, some of the participants' responses explicitly discussed child abuse. One quote described a child who had referred to experiencing sexual abuse by her mother. Following my own emotional response to hearing the information, I questioned whether this should be included, wondering about the potential emotional impact on the reader. However, after much deliberation I decided to include it as I felt it was a reflection of the reality of the children's histories and the sensitive material with which Therapeutic Care Workers (TCWs) work on a daily basis.

Writing Section A was a significant challenge and at times I felt overwhelmed by the amount of literature in the area. Feeling slightly 'lost' in this process raised some self-doubt about whether I could work at this level of academia. A turning point for me was when I reflected on this process and recognised that I had experienced similar feelings earlier in my academic career. Identifying this pattern enabled me to realise that completing a research project, perhaps more so for a research novice, is not simply a factual, scheduled process. I learnt that undertaking research is an evolving process, which interacts with your personal life and past experiences, and that reflecting on this is vital in understanding and processing evoked emotions and expectations at each stage.

Through conducting a qualitative research project using interpretative phenomenological analysis (IPA), I learned to work within an open and curious framework. As this involved the double-hermeneutic of me understanding and interpreting how participants made sense of their experiences (Smith & Osborne, 2003), I was aware of the importance of being reflective and reflexive throughout the research process. Keeping a research diary gave me the space to process my thoughts at each stage, allowing for self-reflection on what was influencing my experiences, both personally and professionally. For example, many of the ideas and values shared by participants were similar to my own from my time as a TCW with Looked After Children (LAC). I realised whilst conducting the interviews and completing the analysis that many of these experiences have impacted on my current working experiences and hopes for my future psychology career. For example, participants' reports of working with the counter-transference resonated strongly with me. Indeed I feel this has influenced my awareness of, and work with, unconscious processes throughout my psychology career to date.

Throughout the project, I was continually reminded of the importance of 'bracketing' (Stedmon & Dallos, 2009) my own experiences of working with LAC in order to interpret the meanings intended by the participants, rather than my own (Smith, Flowers, & Larkin, 2009). While I was conscious of this, it is likely that my previous work as a TCW was reflected to some extent in my identification and naming of emerging categories. My previous knowledge of attachment theory is also likely to have influenced my interpretation of the data and the way that I conceptualised the relationships with children that were being described by TCWs. A quote by one of the TCWs (John) is an example of this: '*and my role [] is to try and build a relationship so she can transfer some of her feelings and I can*

reflect them back.' This quote was one of many from which the master theme 'Therapeutic work occurs in the context of a secure attachment' emerged; it may have been perceived in a different way had I had no prior knowledge of attachment theory or the importance of mirroring and containment within early relationships. I understand that becoming proficient in suspending one's own preconceptions about the data in order to focus on grasping the experiential world of participants is a continuous process of learning, and is a skill that I can develop further in future research I carry out.

I also came to appreciate how research and clinical work can complement each other. For example, I feel the interview skills developed during my clinical work enabled me to quickly establish a rapport with participants, hopefully providing them with a safe space in which to reflect on and share their experiences. This overlap, however, also raised challenges regarding the potential for unclear boundaries with regard to my role. On reflection, this was perhaps a result of my own feelings of 'newness' within researcher role, and a natural drawing back to the familiar (i.e. my role as a psychologist). I particularly noticed myself falling into 'clinician mode' when participants shared difficult emotional experiences connected to the children's traumatic histories, and I found myself wanting to normalise their feelings and responses. As I became aware of this dynamic, I was able to continue without losing focus on the overall aims of the interview. Supervision was an invaluable tool in this process: it enabled me to reflect on my roles and also the fact that participants were reporting that they were receiving support, validation and recognition of their strengths as professionals, facilitated by the support structures in place within the communities. I feel that I was able to mirror this by validating their responses and providing a containing experience.

The input that I received from my supervisors was invaluable; I feel as though I have internalised their guidance and expertise and expect that this will continue to influence me when undertaking future research. Being in a supportive relationship with supervisors also enhanced my confidence as a researcher and I hope to provide others with similar experiences in the future.

Given that this was my first research project using a qualitative methodology, I would appreciate the opportunity to acquire further skills in IPA, for example, by analysing a smaller sample in more depth or by employing focus groups. I also would like to experience other qualitative methodologies, such as grounded theory (Glaser & Strauss, 1967).

2. If you were able to do this project again, what would you do differently and why?

Given the context in which this project was completed, and the restricted time frame, the experience of undertaking this project exceeded my aims and personal expectations. However, with more time it would have been useful to incorporate more carers into the project design and to gain elicit their ideas on implementation and where and how to disseminate to other similar agencies and professional networks.

Another limitation of this project was the small amount of feedback from participants on findings. Due to the time restrictions, I was unable to follow-up and gain face-to-face feedback. I did e-mail participants the findings shortly after completing analysis; two responded and validated my conclusions, however, further clarification would have been useful.

I also think it would have been beneficial to incorporate other perspectives, such as foster parents who cared for the children out of term-time, and other family

members (e.g. grandparents). This may have captured additional dynamics and significant themes for understanding wider systemic aspects of the experience of providing and receiving intervention in a therapeutic community.

3. As a consequence of doing this study, would you do anything differently in regard to making clinical recommendations or changing clinical practice, and why?

The research findings suggest that LAC receiving the intervention of a therapeutic community show gradual and idiosyncratic progress. Compounded by my specialist placement (working within a LAC team), I now appreciate the value of holding this in mind when working with children and those who support them. There may be value in providing psycho-education regarding this issue to other professionals and supporters involved in their care, who perhaps expect quicker clinical change.

The gradual and individual changes that children are reported to make may be too subtle to recognise using commonly-used standardised outcome measures alone, such as The Strengths and Difficulties questionnaire (Goodman, 1997). I would therefore recommend the value of staff keeping qualitative records in the form of detailed process notes in order to effectively monitor children's change throughout and after placements or interventions. These could be combined with the regular analysis of incident reports incorporating setting, antecedents, behaviour and consequences. The use of sophisticated, standardised measures providing normative data would be useful to assess more subtle outcomes – for example, the Social Skills Improvement System Rating Scale (Gresham & Elliot, 2008) could be recommended. Repeated measures can indicate clinical change on the main domains associated with

social skills, including non-verbal communication such as: turn-taking; making eye contact during conversation; cooperation with others; assertion; the individual's ability to show regard for property or work; empathy; engagement with others; self-control; externalising inner feelings; bullying behavior; and, hyperactivity/inattention. Further useful measures could include the Self Image Profile (Butler, 2001), the Coping Inventory for Stressful Situations (Endler & Parker, 1999), and The Resilience Scales for Children and Adolescents (Prince-Embury, 2006). Moreover, detailed clinical assessment of mentalising within the children (Luyten, Fonagy, Lowyck, & Vermote, 2012) may be useful additions to routine practice.

I was struck by how participants expressed the need to foster self-awareness and self-care due to the emotional challenges of the work. Within the therapeutic communities, reflective forums facilitated support for such processes. Other types of services, such as fostering agencies and local authority children's homes, may not incorporate such structures. This highlights an important role for health professionals in offering consultation to outside agencies so as to further facilitate carers' emotional support and personal and professional development.

4. If you were to undertake further research is this area what would that research project seek to answer and how would you go about doing it?

I would recommend replication of this study in order to further the empirical evidence-base thus adding to current descriptive and theoretical literature addressing therapeutic childcare.

Given the importance participants placed on group process and reflection within the communities, it would be useful to gain further insight into how individuals make

sense of their experiences as part of a group. IPA using focus groups could allow for a more detailed and multifaceted account of the experience of working with LAC within therapeutic communities, aiding triangulation of the findings (e.g., Elliot, Fischer & Rennie, 2009). Future studies using similar designs to the current study could recruit young people, social workers and professionals working in care-leaving teams, in order to triangulate findings.

Additionally, a future quantitative study could investigate the pre and post placement outcomes of children leaving care following specialist therapeutic community intervention, compared to a group of children leaving other types of care placement, in order to find out whether there are significant differences in clinical change.

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Section D

Appendix of Supporting Material

Appendix A: Search Strategy and Results

An advanced search identified relevant papers published up to December 2012-Week 3, using PSYCinfo, Ovid Medline, Web of Knowledge, ASSIA and Cochrane Database of Systematic Reviews. Search terms are listed below. Cross-referencing of reference lists of all selected articles was undertaken to identify additional relevant papers. Inclusion and exclusion criteria were applied to abstracts.

Search 1: Therapeutic Care Workers Working Relationally with Looked After Children

Search terms and inclusion/exclusion criteria.

Relation* OR psycho* OR attachment* OR internal working model* OR IWM OR re-parent* OR reparent* OR mentali* OR personal and professional development OR personal development OR professional development OR resilien* OR containment OR therap*

AND

LAC OR Looked After Children OR Looked After young people OR children in care OR adolescents in care OR young people in care OR children in residential* OR residential* OR therapeutic communit*

AND

Carer* OR staff* OR parent* OR care work* OR therapeutic care worker OR TCW OR residential care worker OR residential social worker OR therapeutic residential carer

Included. Papers considering relational/therapeutic work with LAC with emotional and behavioural problems; case studies (due to dearth of literature); outcome studies that also included details of carers' views or perceptions of the model or details of their part in the process of the intervention.

Excluded. Papers not related to children in care with emotional and behavioural problems; therapist focused papers; papers comparing foster care to residential care; evaluations of training models or programmes that do not report views of carers; book reviews; magazine articles; reports.

Search results. The initial search yielded 2578 results. This was reduced to 2413 once duplicates were removed. Following applying the initial exclusion criteria, 1232 abstracts were reviewed. Exclusion criteria were again applied, leaving 37 papers which were read in full. Following a further 18 exclusions, 10 papers were remaining. Nine further papers were identified after scanning reference lists. In total, 19 papers were yielded for the review.

Search 2: Therapeutic Foster Carers Working Relationally with Looked After Children.

Search terms and inclusion/exclusion criteria.

Relation* OR psycho* OR attachment* OR internal working model* OR IWM OR re-parent* OR reparent* OR mentali* OR personal and professional development OR personal development OR professional development OR resilien* OR containment OR therap*

AND

LAC OR Looked After Children OR Looked After young people OR children in care OR adolescents in care OR young people in care OR foster child* OR children in residential* OR residential*

AND

Carer* OR worker* OR foster* OR staff* OR care work* OR Multi dimensional treatment foster care OR MTFC OR therapeutic fostering OR IY OR incredible years OR specialized foster* OR parent-child interaction therapy OR treatment foster*

Included. Studies including therapeutic foster carers working relationally with LAC (Craven & Lee, 2006; Turner & Macdonald, 2011); outcome studies that also included details of carers' views or perceptions of the model, or details about their part in the process of the intervention.

Excluded. Studies without therapeutic foster carers as participants; studies reporting on foster carer interventions that are not classified as therapeutic programmes (Craven & Lee, 2006; Turner & Macdonald, 2011); studies not related to children in care with emotional and behavioural problems; papers comparing foster care to other types of placement.

Search results. The initial search yielded 3245 results. This was reduced to 3116 once duplicates were removed. Following applying the initial exclusion criteria, 907 abstracts were reviewed. Exclusion criteria were again applied, leaving 24 papers, which were read in full. Following a further 19 exclusions, 5 papers were remaining. One further paper was identified after scanning reference lists. In total, 6 further papers were yielded for the review.

Appendix B: Summary Table of Reviewed Papers

Therapeutic Care Workers (Search 1)						
Author	**Aim**	**Country/ Setting/Model**	**Carer /child details**	**Design, Measures and Analysis**	**Carers: application of theory/emotional impact/ protective factors**	**Brief Strengths and Limitations**
Cant (2002).	Case material was presented to argue that psychotherapy needs to be fully integrated into overall treatment of Looked After Children (LAC) within therapeutic communities.	UK. Therapeutic community underpinned by psychodynamic and systemic models, utilising attachment theory (Bowlby, 1969; AT).	Carers: Psychotherapist describing case study, including the relational role of therapeutic care workers (TCWs). Demographics and number of TCWs unspecified. Child: 7 year-old female.	Single case study. Unstructured methods: illustrative and exploratory. No formal measures used.	Communication between all staff necessary for child to be held in mind; carers need to be curious about inner world of children; carers consult with psychotherapist; need to reflect on splitting, projection, denial; toleration of anxiety; need to think about own life experiences and how these may effect relationships with children; 'in house' postgraduate training for carers.	Information described clearly and fully; good time span; only one investigator collected data; techniques for gathering data not described; limitations such as lack of generalisability not acknowledged.
Carter (2011).	Outcomes presented for a therapeutic community for LAC. Residents describe their experience of their relationships with the staff.	UK. Psychodynamic and systemic framework. Applying AT.	Child: N = 8 (5 current residents and 4 ex-residents). Further demographics not specified.	Semi-structured interviews and focus groups. Transcriptions from interviews and notes during interview were organised into themes.	Staff developed their own emotional capacity so that they could facilitate the relational capacities of the young people. Children described increased ability to relate well to others attributing this to feeling 'wanted' by forgiving staff; a feeling of belonging, being 'yourself' and being understood.	Sample may not be representative: recruitment was on a volunteer basis, so may indicate bias. Although analysis procedure described in full, not clear what exact qualitative methodology used.
Collie (1996).	Case material was presented to outline the unconscious processes when	UK. Therapeutic Community	Carers: Child: Two adolescent males. Specific age not	Clinical case study. Unstructured methods:	Carers needed to be able to identify projective identification when strong feelings aroused; carers were placed under intense	Information was described clearly and fully; basis for case selection was presented; case study

	caring for LAC in therapeutic communities. Particular reference is made to projective identification.	underpinned by psychodynamic and systemic models. Applying AT.	given.	illustrative and exploratory. No formal measures used.	emotional pressure; external consultation with psychotherapist was necessary; further training to develop understanding of unconscious processes necessary.	identifies factors explaining phenomena that were observed; poor time span; methods of data collection not presented; only one investigator; information sources not clearly described; no biases, methodological strengths and limitations were acknowledged.
Farragher, & Yanosy (2005).	Case material was presented to illustrate specific issues relating to impact of trauma on individuals (children, carers) and the organisation as a whole within trauma-focused intervention therapeutic communities.	USA. Trauma-focused residential community.	10 year-old female. 12 year-old male. Male carer (age not specified).	Clinical case studies. Unstructured methods: illustrative and exploratory. No formal measures used.	Carers encouraged to acknowledge they brought their own past experiences that may impact on their emotional vulnerability; exposure to violence from children; use of supervision was vital to manage emotions.	Information was described clearly and fully; some empirical evidence was mentioned (measures used in practice); case study identified factors explaining phenomena that were observed; case study of carer included; poor time span; methods of data collection not presented; unclear on number of investigators; information sources not clearly described; no biases, methodological strengths and limitations were acknowledged.
Kohlstatedt (2010).	Case material was presented to illustrate developmental/ relational childcare approach.	USA. Developmental/ relational approach to residential care.	Case study: 12 year-old male. Outcome data: n140. . Further demographics	Clinical case study: Unstructured methods: illustrative and	Carers needed to create positive emotional intensity and attunement with the children; emotional strength needed to maintain relationship; carers faced with aggressive outbursts;	Demographics of outcome sample were not detailed; potential investigator alliance effects; unclear whether assessment was blind. Case study identified

	Outcomes of approach were detailed.		unspecified.	exploratory. Outcome data: Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000). Average scores on CAFAS were presented for a seven-year period. Percentage of children discharged to a family from residential treatment were presented.	adults needed to be self-aware (part of annual appraisal); staff received training into meaning of child's behaviour.	factors explaining phenomena that were observed; poor time span; methods of data collection not presented; number of investigators were unclear; information sources not clearly described; no biases, methodological strengths and limitations were acknowledged; few references.
Moses (2000).	A qualitative study examining residential child care workers' styles of engaging adolescent clients. Analysis focuses on staff practices and behaviour that facilitated a treatment context conducive to healthier client attachments.	USA. Therapeutic Community underpinned by AT.	25 carers 15= women 10 = men Mean age = 33.3 years (range, 23-45 years).	Semi-structured interviews were conducted. Analysis proceeded in three stages, which embodied a synthesis of analytical and interpretive procedures (Marshall & Rossman, 1995; Miles &	Carers found it easier to form attachments with children with shared interest; carers sought to gain insight into children's inner world; high expectations generated distress in staff; carers attempted to attribute meaning to difficult behaviour; carers needed to acknowledge that their own life experiences could act as barriers to relationships.	Although analysis procedure described in full, not clear what exact qualitative methodology used. Random allocation of participants maximized representativeness. No biases, methodological strengths and limitations were acknowledged.

				Huberman, 1994; Patton, 1990). The sequence of data reduction and interpretation involved: I) organizing the data, 2) generating categories and themes from the raw field data, 3) developing a coding scheme, and 4) testing emergent hypotheses against the data by searching for alternative explanations.		
Tolmacz (2003).	Case material was presented to illustrate the functioning of a therapeutic community for adolescents, which was underpinned by AT.	Jerusalem. Therapeutic community underpinned by psychodynamic and attachment theory.	Adolescent female (exact age unspecified).	Clinical case study. Unstructured methods: illustrative and exploratory. No formal measures used.	Carers faced with violent emotional outbursts; carers acted as a 'secure base' - through providing residents with a sense of security and encouraged interactions; communication between staff was encouraged to reduce 'splitting' and 'acting out' among adolescents; large staff team reduced burden on individual carers; carers needed to bear anxiety, helplessness and aggression.	Information was described clearly and fully and reflected phenomena it intends to illustrate; good time span; only one investigator collected data; techniques for gathering data are not described; limitations such as lack of generalisability not acknowledged.

Tziotziou et al., (2006).	Case material was presented to illustrate the functioning of a therapeutic community for adolescents.	Greece. Therapeutic community underpinned by psychodynamic theory and AT.	Adolescent male (age unspecified).	Clinical case study. Unstructured methods: illustrative and exploratory. No formal measures used.	Carers built secure attachment with key-child; carers needed to have sufficient self awareness in order to bear and process the undesirable unconscious feelings that were projected onto them.	Information was described clearly and fully; basis for case selection was presented; case study identified factors explaining phenomena that were observed; poor time span; methods of data collection not presented; only one investigator; information sources not clearly described; no biases, methodological strengths and limitations were acknowledged.
Whitwell (1998).	Case material was presented to illustrate the functioning of a therapeutic community for children.	UK. Therapeutic community underpinned by Psychodynamic and AT.	Three male children (age unspecified).	Clinical case study. Unstructured methods: illustrative and exploratory. No formal measures used.	Carers needed to be able to identify unconscious feelings when strong emotions were aroused; carers were placed under intense emotional pressure; external consultation with psychotherapist was necessary; further training to develop understanding of unconscious processes was necessary; the external environment, including management supported the processes for the carers.	Information was described clearly but not in enough detail; poor time span; methods of data collection not presented; only one investigator; information sources not clearly described; no biases, methodological strengths and limitations were acknowledged.

Therapeutic Foster Carers (Search 2)						
Author	**Aim**	**Country/Setting/Theoretical underpinning**	**Carer /child details**	**Design, Measures and Analysis**	**Carers: application of theory/emotional impact/ protective factors**	**Brief Strengths and Limitations**
Bywater et al. (2011).	To investigate the implications and effectiveness of the Incredible Years parenting programme (Webster-Stratton 1998) in supporting foster carers in managing difficult behaviour,	Wales. AT and Social learning theory (SLT; Bandura, 1977).	N = 46 foster carers participated. Intervention group (n = 29) comprised foster carers with 14 female and 15 male looked .The control group (n = 17) comprised 8 female and 9 males.	Measures were administered at baseline and 6-month follow-up. Measures used: The Parenting Scale (Arnold et al., 1993). Beck Depression Inventory (Beck et al.1961). Eyberg Child Behavior Inventory (Eyberg & Ross, 1978 The Strengths and Difficulties Questionnaire (SDQ); Goodman, 1997. In addition, Thematic content analysis was used to assess foster	Group setting trained foster carers to apply AT and SLT in their practice; foster carers were trained to address the emotional and behavioural needs and difficulties of their foster children. Improvements in foster carers confidence, stress, depression were shown. Experience of being in a group acted as a protective factor. Analyses showed a significant reduction in child problem behaviour.	Control group was used. Implementation fidelity of the programme was accounted for. Small sample size.

				carer feedback following programme attendance.		
Westermark, Hansson, & Vinnerljung (2007).	Study addressed how foster carers perceive the components and core terms specific to Multi-dimensional Treatment Foster Care (MTFC).	Sweden. SLT and systemic approach.	N = 28 Foster carers.	Structured interview. Open, flexible questions aiming to obtain information about attitudes towards the programme. A 'clustering' method of qualitative analysis was undertaken (Starrin, Larsson, Dahlgren & Styborns, 1991). Structured questionnaire (74 questions intended to obtain information about attitudes towards the programme. Standardized and open answer alternatives, divided into different sections. Seven point rating	Protective factors and factors enabling the application of theory in practice included access to advice from supervisors 24 hours a day, a weekly support group and specialised training in the MTFC approach. Positive relationships with clinical supervisors was reported. The systemic approach offered further protective factors as foster carers felt supported. Predictable support was perceived as very meaningful to foster carers.	Standardized measures were not used. No follow-up. Researchers undertook analysis. No quality control methods utilized during qualitative analysis. This may indicate bias. Small sample size. However, sample included the total population of MTFC in Sweden at that time. Factor analysis did show that attitude scales were stable with high reliability.

				scale.		
McNeil et al. (2005)	Highlighted the need for disruptive behaviour disorder treatment for children in foster care; discussed.	Parent Child Interaction Therapy (PCIT).	30 foster parent-child dyads.	Measures were taken pre and post intervention and at one month follow-up. Eyberg Child Behavior Inventory (Eyberg & Pincus, 2000). Foster Parent Training Satisfaction Survey (no reference provided). A structured interview consisting of 20 questions regarding carers' use of techniques learned in the workshop	Carers reported a decline in how problematic they viewed their child's behaviour to be over a five month time period. Results suggested that the carers were adjusting to or managing the child's behaviour more effectively. Additionally, carers reported high levels of satisfaction with the training and reported using the skills taught.	Lack of comparison conditions with randomization to groups. Reliance on parent-report data. Small sample size.
Silver & Holmes. (2011).	Study reported about a group intervention that combined aspects of Incredible Years parenting groups (Webster-Stratton, 1998) with AT,	UK. Foster parent group. AT. SLT.	Exact N unspecified Adoptive and foster carers, including therapeutic foster	Measures used: Parenting Stress Index - Short form (Abidin, 1990). Questionnaire focusing on adult-	Participants found it helpful being in a group situation with other foster carers. They conveyed that the group setting enabled them to learn	No control group. Investigators were also group facilitators, which may have indicated bias. Sample size unclear.

	developed to help therapeutic foster carers understand and manage their child's behaviour and improve their relationship with the child.		carers.	child relationships, developed by a national network of clinical psychologists working with LAC (no reference provided). Incorporated a Likert scale. Managing behaviour with attachment in mind questionnaire (no reference provided). Written for use with this particular group intervention. Results were analysed using a thematic content analysis.	about AT and how to apply it to their work with the children. Increased understanding of reasons behind behaviour was reported. Confidence in managing difficult improved throughout the group. Parent-child relationships were viewed as more positive. Therefore, group seemed to be a protective factor and facilitated carers applying theory.	Lack of standardised measures.
Timmer, Urquiza and Zebell (2006b)	Aimed to evaluate the effectiveness of PCIT for non-related foster carers and their foster children compared with non-abusive parent-child dyads.	USA. SLT.	75 non-relative foster carers and their foster children. 98 non-abusive biological parent-child dyads.	Child Abuse Potential Inventory (Milner, 1986). Child Behaviour Checklist (Achenbach & Rescorla, 2000). Eyberg Child	Following PCIT, drops in child behaviour problems and care giver distress was shown. Coaching carers to change their interaction styles appeared to improve relationships. Foster carer reported reflected a shift in	Significant demographic differences between groups were included as covariates in the statistical analysis. No control group. No follow up.

				Behaviour Inventory (Eyberg & Pincus, 1999). Parenting Stress Inventory (Abidin, 1995). Symptom Checklist 90-R (Derogatis, 1994).	their own attitudes towards children, rather than a change in children's behaviour. Distressed foster carers showed good attrition rates. Approach provided therapeutic support to foster carers.	Multiple investigators for observational data were not utilised.
Timmer, Urquiza, Herschell, McGrath, Zebell, Porter & Vargas (2006a).	Aimed to evaluate the effectiveness of PCIT for one parent-child dyad.	UK.	Foster mother (41 years). Foster son (4 years).	Single case design. Observational methods:- The dyadic parent-child interaction coding system (Eyeberg & Robinson, 1982). Standardised measures:- Eyberg child behaviour inventory Child behaviour checklist Parenting stress index	Foster carers facilitated positive relationships with the children. Applied SLT through following the child's lead when playing, attending to positive behaviours, consistently praising, increased patience, and implementing 'time-out' when necessary. Results indicated that children's behaviour improved. Foster parent confidence increased due to working with the approach. Protective factors included support from therapists.	Small sample size limited generalisablity. The therapists undertook the observation, which may indicate bias. A research assistant who achieved 85% reliability re coded Twenty percent of observational tapes. Intercoder reliability was good.

Summary Table of Theoretical Papers for review question 1: outlining background of therapeutic residential care, its principles and theoretical rationale

Author	Brief Overview
Bloom (2005).	The Sanctuary Model of organisational change was applied to residential child treatment. A trauma-informed method was underpinned by systemic approaches. The theoretical underpinnings of the model were addressed, with emphasis on the parallel process where chronic stress is seen in the behaviour of children and staff.
Collie (2008).	The author explored methods of working with residential child care foster care agencies in developing a psychotherapeutic culture. He suggested that such a culture can only be built on the firm foundations of clear organisational boundaries and tasks. It was argued that senior managers must have an understanding of unconscious processes and how they affect relationships between adults and children and between colleagues within the organisational hierarchy.
Cooper (2002).	Author described concept of 'opportunity led work' which symbolises the holistic, systemic practice within therapeutic communities for young people. Explained that therapeutic work is not confined to the 'therapeutic hour', rather - the work is facilitated by carers and potentially occurs during the course of everyday life, including the interactions with carers. It was distinguished from the more planned or scheduled activities in that it draws attention to the opportunities for communication and insight occurring on a day-to-day basis.
Cross (2010).	Paper explored aspects of provision of specialist therapeutic residential child care. Factors intrinsic to successful intervention were summarised as: staff training in child development and effects of childhood trauma; support and supervisions structures; understanding 'tensions' within the staff group; therapy services and education for children.
McLellan (2010).	Author presented a summary of the main principles, which informed the work of residential therapeutic communities for children. Principles were underpinned by psychodynamic and attachment theories. Author explained how such principles facilitated the carers in facilitating healing relationships with the children, including support and management structures and consultancy.
Rose (2002).	Discussed role of therapeutic communities as utilising group process and individual therapy for children and adolescents. The relationship between carer and child was described as intrinsic to the success of intervention. The importance of carers understanding the psychological and often unconscious process involved in such relationships was outlined.
Sprince (2002).	A description of the organisational structures within therapeutic residential units for traumatised and sexually abused adolescents. Set out how a staff group, which support the children, actively work on understanding themselves and their own process of relating to others.
Tomlinson (2005).	Paper described the type of thinking required by staff working in therapeutic communities for LAC. Such thinking was concerned with understanding the explanations behind the behaviours exhibited by the children. Emotional containment was also discussed. The structures in place to support such processes for the carers were outlined.
Watson et al (2006).	Paper outlined a model for the assessment, selection and training of staff to work in residential care. Capabilities included flexibility: a non judgemental approach, ability to modify own behaviour as required, emotional awareness: recognising and understanding own emotions, and the emotions of others; manages own and others' emotions effectively.
Ward (2002).	The concept of 'opportunity led work' was introduced (as explained by Cooper, 2002). Processes of assessment, decision-making, action and closure

	were described as being involved in the briefest of interactions between children and staff. Vignettes were used to illustrate how the concept was applied in practice.

Appendix C: Information Sheet

Salomons Campus at Tunbridge Wells
Department of Applied Psychology
Faculty of Social & Applied Sciences

Information Sheet for Participants:

'The experiences of residential carers working in therapeutic communities for Looked After Children'

You have been invited to take part in a research study, which is part of a Clinical Psychology Doctorate training programme in the Department of Applied Psychology at Canterbury Christ Church University. This sheet will provide you with information about why this research is taking place and what will be involved. This information is important as it will help you decide if you would like to be involved. If you would like to learn more, if something is not clear or if you would like to ask me a question then do not hesitate to ask me at any time. You can contact me on (removed).

What is the purpose of this research project?

This study aims to explore the experiences of you who work with Looked After Children. Presently there is little research about therapeutic communities and the in-depth work which is undertaken in such organisations. By gaining information about your experiences, your work with young people and how you cope in the face of challenging experiences can be represented to outside agencies.

I feel that it is important to consider the thoughts and views of you who work directly with these young people as you have the most insight into what improves the lives of the children and young people and what helps to support your work with the young people.

Why have I been approached to take part in this research project?

It would be useful and interesting to gain insight into your experiences of working with Looked After Children as you have the greatest insight into your role and the impact of your work on the lives of the young people.

Do I have to take part?
Taking part is undertaken on a voluntary basis. Your involvement is completely separate from your role at work. Whether you take part or not will have no bearing on your work. It is completely up to you whether to take part or not. If you decide to take part, you will be asked to sign a consent form where you will tick that you have read this information leaflet, that you agree to take part, that you are aware that you can withdraw your participation at any time and that you are aware of the procedure should you wish to make a complaint about any aspect of the research or the research process.

What is involved?
The research will involve undertaking an interview with me at your place of work. The interview will last for about an hour. The interview will be recorded on a Dictaphone, which I will later listen to and transcribe. All identifying information will be anonymised. This information will be kept on an encrypted memory stick and any printed information will be kept at Salomons campus of Canterbury Christ Church University in a locked filing cabinet. All the information and material will be destroyed after 10 years.

Will the information that I share be kept confidential?
All information collected during this research project is kept strictly confidential at all times. The information that you offer, which could include direct quotes is likely to be included in the study, however, this will be confidential and no identifying information will be included.

What will happen with the information that I share during the interview?
A written summary of the study will be available to all participants once the research has been completed. You will also have the option of having an individual meeting or telephone call with me to go through the findings of the study. The findings are planned to be published in a research journal – but as mentioned above, all information will be kept completely confidential.

Does this research have ethical approval?
Yes, this project has full ethical approval from Canterbury Christchurch University.

What should I do if I want to take part?
If you feel that you would like to take part, please pass your name on to (removed: name of Director of establishment). I will be in touch very soon.

What should I do if I want to make a complaint?
If you would like to make a complaint, then you can contact the Chair of the ethics committee at Canterbury Christchurch University *(removed: contact information).*

<u>Contact for further information</u>
(removed).

Appendix D: Consent Form

Salomons Campus at Tunbridge Wells
Department of Applied Psychology
Faculty of Social & Applied Sciences

Consent form for participation in the interview regarding Therapeutic Care Workers' Experiences of working in therapeutic communities for Looked After Children

Please tick Δ as appropriate

Δ I understand that this is an interview, and the purpose of this interview is to share personal experiences of my work within (insert: the therapeutic children's home).

Δ I understand that the interview will last for approximately one hour and that the trainee psychologist will record the interview using a dictaphone. These notes will then be typed up so that my views, experiences and comments can be identified. I understand that some of my quotes from the interview may be printed in a written account of this research project.

Δ I understand that any information I provide will remain confidential and only be used for the purposes of this research. I understand that all identifying information and the content of the interviews such as quotes will remain anonymous.

ΔI understand that being involved in this research is not connected to my role within (*removed*) and it is not expected as part of my job. If I decide to withdraw or not take part in this research then my position at (insert: the therapeutic children's home) will not be effected in any way.

Δ I understand that taking part in this interview is voluntary and I may withdraw at any stage, without giving any reason.

Δ I understand that should I wish to complain about any aspect of this research procedure, then I can contact (removed).

∆ I have read and understood the information and agree to take part in the interview.

_____	_____
(Participant)	**(Trainee Clinical Psychologist)**
_____	_____
SIGNATURE	**SIGNATURE**

If at any point you have any questions or concerns, please contact *(removed).*

Appendix E: Interview Schedule

Thank you very much for taking part in this research project and for agreeing to take part in this interview. The interview will last for about an hour.

I am really interested in what is like for you to work as a therapeutic carer. I am interested in both positive and negative experiences of your role. So, please tell me about whatever your experiences are like. I am not looking for any particular answers.

Please share only as much as you are comfortable with or in a way that feels OK for you.

It is also fine not to talk about some of your experiences. I would like you to be comfortable with what you share with me, ok?

Can I check with you again if it is ok for me to record the interview (go through confidentiality, option for debrief session after interview)? Do you have any questions? Shall we start?

Interview Questions

1. ***Exploration of the experience of Therapeutic Care Workers working in a Therapeutic Community for Looked After Children, in order to explore how Therapeutic Care Workers understand the nature of their work with young people*****.**

- **Tell me about your work with young people**
- **What is it like working with these young people?**
- **Can you tell me about your experiences of working with young people?**
- **Can you tell me about any negative experiences?**
- **Can you tell me about any positive experiences?**
- **Are there any ideas or theories that inform your work with the young people?**

2. ***Exploration of what they feel helps to build their resilience as Therapeutic Care Workers.***

- **This work seems tough, what is it that helps you?**
- **Can you tell me about what you think helps you cope/remain responsive?**

3. ***What do they feel that they do in their work that is helpful to the children?***

- **What to you feel you do for the child that is helpful to them?**

- **What, from your experience, are the key ingredients for making a positive difference/ improving the lives of young people?**
- **What have you noticed about changes in the children since they have been living here?**

Secondary responses:-

What happened; what did you feel/do; how does that feel; what triggered that response; what sense did you make of that experience; how are you understanding that; what does that mean to you?

Appendix F: Summary of Study Findings

Dear Chairman of ethics committee / Participant *(deleted as appropriate),*

Re: Research project: 'The experiences of residential carers working in therapeutic communities for Looked After Children'

I am writing to inform you of the outcome of the above research project which you approved/ in which you took part *(deleted as appropriate).*

Research context

Looked After Children (LAC) living in residential care have been highlighted as the most vulnerable children in care (DH, 2009). There is a sub group of LAC whose emotional and behavioural needs require placements in specialist, therapeutic children's homes. The theoretical underpinning of therapeutic residential care has a strong evidence-base, which includes psychodynamic theory, mentalisation, and attachment theory, and therefore has obvious clinical utility. However, within the context of therapeutic child care, there is limited empirical evidence. The theoretical, descriptive stance of most literature on therapeutic childcare limits the reliability and validity of findings. The aims of therapeutic childcare, as set out in the literature, are mediated through Therapeutic Care Workers (TCWs). Research to date illustrates little synergy between extant theory and carers' perceptions of their role.

Research aims

1. What are TCWs' perceptions of facilitating therapeutic, relational work with LAC in therapeutic residential care?
2. What are TCWs' experiences of the impact of their work on their own psychological wellbeing?
3. What do TCWs see as factors that enable them to develop and maintain the necessary resilience to cope with the emotional demands of the role?
4. What are TCWs' experiences of potential change in the children following a TC intervention?

Methods

Semi-structured interviews were carried out with nine TCWs and data were analysed using Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009).

Results

Five master-themes emerged from the interviews. They are summarized below:

Therapeutic Aspect of Group Living

Being part of a group that places importance on communication was central to TCWs work within the communities. Participants described forums for open and honest reflection that were incorporated into everyday practice, facilitating reflection on their practice, including group dynamics. Feelings of relief and dependence were

associated with reflecting as part of the group process, indicating that they found the forums a source of support. Some acknowledged that the open reflection was an anxiety provoking experience, but nevertheless crucial for practice.

Importance of Carer-Child Relationships

Relational aspects to the role were at the forefront of the TCWs experiences. This theme captured the centrality of how developing secure relationships facilitated therapeutic work with the children. It was striking how participants described how their relationships enabled the child to build trust and learn an alternative way of relating to people. Providing the children with a sense of predictability that differs from the context of their previous relationships appeared to be viewed as important, and seemed intrinsic to facilitating secure attachments.

Working With The Unconscious

This theme reflects how TCWs attend to unconscious processes. Sometimes this involved participants referring to specific psychodynamic concepts. Other descriptions included the capacity to be reflexive, and thinking about the meanings beneath behaviours, despite working in highly emotive situations. Despite some carers having less than one year's experience in their role, participants shared that they incorporate concepts such as projection, transference, and counter-transference, and utilise attachment theory to inform their work. Responses appear to suggest that carers have internalised such concepts and use them as therapeutic tools. Participants had insight into the inner-world of the children; reflecting on some of the experiences of the children, as they perceived and experienced them through unconscious and conscious channels.

Personal Meaning Of Professional Role

Participants conceptualised their role as involving an intricate combination of experiences, including a widening knowledge, belief in their approach, balancing personal and professional life, together with a range positive and negative emotional experiences. Participants expressed a range of emotions that they experience as part of their role. Most participants expressed feelings of enthusiasm and hope when describing their work; this seemed due to their increased confidence in their approach, which they attributed to training and support structures. There was a sense from the majority of participants that it was necessary for them to invest and reflect on parts of themselves, their personalities and values, because the use of self constituted an important 'therapeutic tool'.

Childrens' Progress

Participants viewed children making progress throughout their placements, in gradual, individual steps that were specific to each child. Common themes reflected how resilience and self-esteem was seen to increase, together with children developing an identity and sense of self.

Conclusion

Findings suggested that there is a synergy between relevant theory, conceptual and descriptive accounts of therapeutic childcare, and TCWs' perceptions of their role. The use of IPA has illuminated extant theory by providing examples of lived experience of the TCWs, demonstrating how they incorporate underpinning theory into their daily, clinical practice. Further research is needed to extend the findings, by

using qualitative methodologies to investigate the intricate processes involved in the work, as well as quantitative studies using sensitive outcome measures. The publication of data already collected within the communities is also recommended.

Thank you for participating in this project. If you have any further questions, then please do not hesitate to contact me on *(contact details removed).*

(Name of researcher)

Appendix G: Approval Letter From Ethics Committee

This has been removed from the electronic copy.

Appendix H: Example Transcript

This has been removed from the electronic copy.

Appendix I: Initial Emerging Codes

Master themes	Sub-themes	Initial themes related to subtheme
Therapeutic aspect of group living	Open and honest reflection	Group living provides opportunity for observations and reflection Parallel process occurs in group dynamics Management are involved in reflecting on group dynamics Staff utilise mutual support and supervision Reflection on group process is relied upon Honesty within team Reflective practice occurs in group context Reflection and communication within the group context is needed Reflective practice: learning from experience Open and honest reflection is part of the culture Modelling being open and honest in front of the children Staff support and supervision is necessary Staff support and supervision is valued Reflecting in the large group can feel challenging.
	Individuals are part of a group	Staff support within team Can't work in isolation Wider group supports and is aware of all relationships

		We need one another It feels like being part of a family unit Relationships between adults and children occur within the group context Reflection occurs individually and as a group Trust within team is needed
The importance of carer-child relationships	Therapeutic work occurs in the context of a secure attachment	Relationships are varied Holding Primary care is facilitated Containment Maternal preoccupation Building trust within close relationship Re-parenting relationships Relationships need to be timely Relationships take time Relationships facilitate containment Secure attachments enable the work Secure attachments offer the children alternative internal working models Relationships with children can vary Relationships are on the children's terms Secure attachments allow children to be contained Secure attachments show the children an alternative way to relate to people Building confidence in the context of secure attachments Secure attachments with adults offer child

		alternative Internal Working Models, especially for children with previous traumatic relationships Consistency and boundaries are facilitated within the relationships Facilitation of a secure attachment Maternal preoccupation Facilitating secure relationships enables therapeutic work Developing secure attachments with the children is at the crux of therapeutic care work
	The importance of consistency and clear boundaries	Continuity of care is important Providing the children with the consistency they have not had in the past, enables them to feel safe Everyone needs to be aware and keep to the house rules/boundaries Being consistent with the children is paramount Establishing boundaries runs parallel with building relationships All staff need to be consistent with each other
Working with the unconscious	Working with psychodynamic concepts and attachment theory	Working on two levels of conciousness Applying psychodynamic model Using transference and countertransference Projection Attachment theory Naming feelings Working with transference and counter-transference

		Timing Awareness of splitting Projective identification Symbolic communication Two levels of work - conscious and unconscious Projective identification occurs between all community members Using transference and countertransference as a tool Working with defences Exploration of past trauma Staff need to develop self-awareness in order to be aware of countertransference Staff need to separate their own feelings from those coming from the child Adult self-awareness is essential in context of all relationships within the community A relief to learn to use concepts Concepts provide extra tools for work Transference and counter transference provide valuable insight
	Reflexivity	Reflexivity Need to think carefully in the moment Responding not reacting Taking a step back from the situation, working out what is going on Using reflection to read situations clearly Having that space to think through in your mind, despite what's going on

		Learning to read your own feelings, rather than reacting to them Keeping calm, thinking clearly, despite adrenalin pumping round your body Be aware of triggers of difficult situations
	Behaviour understood as a communication	Behaviour is a communication Behaviour demonstrates inner world of children Children act out for a reason Behaviour is perceived as a communication of child's inner world Learnt behaviour in order to survive Need to understand reasons behind behaviour Violence is a breakdown in communication - what have we missed? Their behaviour can tell you a lot about what they have experienced in the past They act out because they can't verbalise what is going on for them What are they trying to tell you by behaving in that way?
	The inner world of the children	Child's inner world is held in mind Children experience undesirable feelings: rage, anger, terror, frightened Child's previous traumatic experiences are thought about You are faced with information you don't want to know about, but we have to go there Transference means we can feel like the abuser

		Sexual abuse means terror, confusion and shame Children remain frightened of their abusers She has been sexually abused by her mother Children's undesirable emotions scared, anxiety, anger Too much to think about all the time Identification with the aggressor Bullying
Personal meaning of professional role	The value of and confidence in the role	Staff value mutual support and supervision Staff value training Group process is valued TCWs value their role Staff enjoy their job More than just a job Believe in what they are doing Faith in the approach Staff confidence in approach Training is valued Loved the college course Staff promoted internally, indicating management also have faith in the staff they have trained Staff perceive team as supportive
	Emotional impact of the role	Traumatic experiences occur Transference means staff exposed to difficult feelings

		Holding on to undesirable feelings: despair, anger, sadness, abused, abusing, scared, threatened. The job is tough - emotionally and physically Violence towards staff occurs Staff bear the brunt of the children's feelings Positive feelings experienced: hope, admiration, love, maternal feelings Emotions experienced are changeable Staff experience re-living of trauma Adults experience undesirable feelings: sadness, terror, anger, disgust, anxiety Sense of hope Relationships can feel positive to staff The job is an emotional rollercoaster Staff have fun and follow own interests Varied experiences in role - some difficult, some fun
	Investment of the self	Personal investment of self The impact of personal issues on professional practice and vice versa Reflection on self can be painful Increase in self awareness The journey to self-awareness (in staff) can be a struggle Adult resilience is a pre-requisite for the role Being yourself

		Impact on of professional on personal life and vice versa Bringing your true personality to the job More than just a job - a personal journey Investment of the self (adult) The impact of personal issues on professional practice and vice versa Investment of and discovery of the self (adult) Sharing parts of self Increase of self-awareness due to group context
Childrens' **progress**	Progress is individualised	Progress is individualised Hard to measure Small steps Success is child dependent Can just be the little things Progress indicated by sense of pride Progress indicated by child's new ability to verbalise feelings Easier to give examples for each child Experiencing individual progress as positive Have to stop and think to notice progress
	Building resilience	Resilience increases in small steps Building resilience Building self-esteem Group living facilitates interdependence

		Learning to problem solve Preparation for outside world Not to be 'wrapped up in cotton wool' Facilitating positive experiences for the children Give them the tools for life Building resilience (self-esteem, life skills)
	Discovery of a sense of self	Difference between chronological age and emotional age On admission, children lack a sense of self Help them accept parts of themselves Working with defences Some children have a 'false self' Encouraged to develop own interests Build a sense of identity They copy other children Help them find who they are Coming to terms with the past Helping them to verbalise and self regulate emotions

Table 6: Initial emerging codes following analysis of first four transcripts and how they relate to master and sub-themes

Appendix J: Themes from Bracketing Interview

- Caring, but in a therapeutically informed way. So two levels of care.
- I felt very committed to the job.
- Good experience for a career in psychology
- Empathy with the children
- Intense experience - you feel like you live with the staff and the children
- Fun
- Very emotive - listening to the difficult histories of the children.
- Daily handovers helped me offload.
- Supportive staff team helped me.
- I was friends with my colleagues.
- Finding hard to remember what it was like - I committed so much of my time to the job. Maybe I over-did it, and I don't want to go back there in my mind!
- I worked long hours - 60-70 hours a week. I had irregular supervision; I think that will have changed.
- Took me a while to realize it was more than just child-care. I expect participants will be more aware from the beginning of their employment.
- I remember feeling institutionalized and found my transition home difficult.
- The level of responsibility felt too much sometimes.
- Being on the receiving end of violence was difficult.
- Violence was understood as a breakdown in communication.
- I expect participants to mention the overwhelming emotions associated with being immersed with the children in close attachments.
- I loved the games. Holidays were difficult for me. I expect holidays to be a positive aspect to participants' experiences.
- Feeling important to the children was nice. It feels gratifying to be needed.
- Theories I think will come up: transference/countertransference (I wish I had learnt this earlier); attachment theory (the importance of secure attachment for learning and development); maternal preoccupation; symbolic communication; therapeutic play; defences.
- Being psychologically minded helped me.
- Linking theory to practice helped me, made me interested and motivated.
- Children acted out less, learnt to verbalise.
- Relationships with the children helped them to feel contained.
- Keeping the 'thinking space' is important.
- Need self-awareness.

Appendix K: Abridged Research Diary

1st February 2011 – Reflective interview

I undertook an interview today, with a fellow trainee in order to raise my preconceptions about the research interviews. We followed the same interview schedule that I am planning to use with participants, with the same questions, but an added question after each one, namely "how do you expect that the participants may answer that question?" I found the experience interesting and beneficial. Once I started talking about my previous role as a TCW, it surprised me how much came back into my mind, despite it being over ten years ago that I left. It got me thinking about why I had chosen this area, along with what my previous experience had affected my expectations about the potential findings of the study. At this point, I am hoping I have got enough out of this experience to help me when I come to analyse. I have never undertaken qualitative research before, so I feel very new to it and quite challenged! However, it also seems interesting and an almost 'natural' process to go thorough – I do understand the importance of thinking about my preconceptions to avoid bias. But I think I will have to revisit my interview many times throughout analysis.

24th March 2011 – Interview 1

This was my first interview. I did not feel initially apprehensive about the interview, as it was a pilot interview and I was regarding it as a 'learning process'. Just before I met the participant, I did feel a little nervous about my interview style, and whether it would be 'good enough'. Perhaps this was because this was the first time I had undertaken an interview as part of a research study. At first I did not feel that the interview flowed very well. It felt a little bit 'stop and start'. However, after listening back to the interview when I arrived home, it sounds like quite a good rapport was developing between myself and the participant. So perhaps it was my own anxiety in the early stages of the interview. I found the interview an interesting and enjoyable process. I was struck by the ease at which the participant spoke and reflected on her work with less prompting than I envisaged. I wondered whether this was a reflection of the amount of time she reported that they spent speaking about their practice with each other in various forums.

4th May 2011 - Interview 2

I was struck that the participant seemed rather anxious in her manner and in the way in which she responded to the questions. At the beginning of the interview, therefore, I was preoccupied with helping her feel at ease. I tried to build rapport, and after about twenty minutes, she seemed to relax a little. Some of the content of this interview was highly emotive and unpleasant to hear. I noted that she spoke explicitly about a child's accounts of sexual abuse by her mother, and also detailed an event which involved children killing animals. Feelings that came up for me included shame, embarrassment, horror, shock and sadness. It made me think that dealing with this kind of emotive material is part of their everyday practice. Although she did not seem 'desensitized' to the difficult information, the real issues at hand were not

denied, but dealt with. It made me realise that the support systems in place must be strong, in order to maintain the resilience of staff working with such difficult feelings or situations.

15th May 2011 – Interview 3

I really enjoyed conducting this interview, and felt positive, happy, attentive and interested throughout. I later wondered whether this may have been a reflection of the participant's enthusiasm for her work. I found her comments about her ability to separate her own feelings from those of the child's despite being racially insulted very interesting. I felt admiration for her. In my mind I was making links between some of her comments with those of interview 2 and 1. I was aware that my mind was racing ahead, and I felt a need to remind myself to keep an open mind and prepare for interview 4.

16th May 2011 - Interview 4

I found the personal reflection in this interview slightly overwhelming. I was not expecting participants to share such personal information about their own lives. Sharing information about his own family was quite moving. It made me realise how much is expected of them in this role - they are required to reflect on their own childhood, family roles, so as to increase their self-awareness and allow them to own their own feelings and understand their countertransference. The depth of the personal information shared, made me think about the impact of the work, particularly because the impact was quite intense and emotional for some participants.

6th June 2011 - Interview 5

In this interview, I was struck by the theme of relationships, and how establishing secure relationships seemed to be at the crux of the work. I had not expected this, but so far all of the participants seemed to have spoken at ease about how they use psychodynamic concepts within their work. Although I knew they had all received training in such concepts, I had not expected them to seem so internalised and part of every-day practice. A sense of fun and enjoyment also came across to me. The participant seemed to relish in remembering and telling me about all the 'fun' activities they undertake to enable the building of self-esteem and sense of identity for the children. I was also struck by the level of personal investment that this participant seems to have made in the job. He even comes in on his day off to attend reviews for his key child.

10th June 2011 - Interview 6

Again, during this interview, I was overwhelmed by the genuine feelings of love and care that the participant seemed to have for the children. She too shared lengthy examples of how she constantly worked and reflected on her own life experiences and how this affected her work with the children. The participant spoke about the sensitive job of maintaining personal and professional boundaries, whilst sharing enough information with the children about her own life to be genuine and 'real' to them. This reminded me of some of the comments from interview 4.

10th June 2011 - Interview 7

I conducted this interview with a participant who had showed me round on my visit to the house in which he works. Seeing him in a different context threw me a little, and I had to remind myself to stay in the researcher role. Once the interview had got

underway for at least ten minutes, I felt that the interview was flowing well. Similarly to the previous two interviews, I was struck by the automatic reflections on connections and differences that this participant drew from his own life and that of his working life at the residential establishment. The participant spoke about his own children, and how his role at work has affected his parenting. Drawing these parallels between personal and professional roles was something I had not expected.

12th June 2011 – Interview 8

I was amazed that the participant, who was a housekeeper, although spoke with less "jargon", still spoke about similar concepts to that of therapeutic care workers. The participant spoke about the importance of building close relationships with the children, with the foundations being trust and consistency. She was also able to reflect on her feelings that are brought up in the work, recognising that such feelings can be ambiguous and changeable. Her take on the children's progress was interesting and she gave examples, illustrating that success is measured in very small steps and is different for every child.

17th September 2011 - The process of analysis: the first steps

There has been a long break between conducting the interviews and beginning analysis. However, I have done all the transcribing myself, this has helped me once more feel connected and familiar with the data. I was left wondering whether this is an advantage or a disadvantage? I feel really familiar with the transcriptions, but I also feel a little overwhelmed with information. I wondered whether to leave a gap between these processes. However, after further consideration, I decided to take one of the transcripts that felt fresh in my mind. I listened to the transcript while reading it. I found this really helpful and have done this for each transcript. For each interview, I made notes on linguistic comments, descriptive comments, and conceptual comments. This felt very useful. Listening to the interviews and reading and re-reading the transcripts really brought back the data vividly. Taking a week off placement, and focusing only on this has allowed me to immerse myself in the data completely.

22nd September 2011- The process of analysis: developing emerging themes

I have been thinking about potential themes. I used abstraction to look for connections across themes. I found it useful to print out a list and cut up the list so each theme was on a separate piece of paper. This helped me think about how different themes could be related to each other. I got quite confused towards the end of this process. The overall theme of 'resilience' seems to have such varied themes. I am now starting to doubt my judgement. I put it away for a few days and came back to it with a 'clear head'. I decided to follow the same process for each transcript.

I have felt overwhelmed by some of the quotes. I feel that the way in which some of the participants have been explaining, in their own terms, the tools of transference and counter-transference and how they use them. A lot of the examples are without jargon and it's really coming across to me that these principles are so embedded in the culture, that the carers are integrating these principles into their daily practice almost automatically. I am looking forward to the write up where I can add some of these admirable quotes.

24th September - continuing analysis

I found it useful to take a few days break from being immersed in the transcripts. I have thought through a process that is going to alleviate some of my anxiety and doubt about the way I have coded the themes. After analysing 4 transcripts, I cut out all the superordinate themes (there are a lot!) for each transcription. I will write the number of the transcription on the back of this piece of paper. I was then able to combine initial themes to reveal superordinate themes. I then re-read my own interview to check it against my potential preconceptions that I identified. Some of the superordinate themes were expected from me, for example the importance of developing secure attachments with the children, and the use of psychodynamic concepts in practice. What I had not predicted, was the internalised, embedded nature of these concepts within the groups. They seem to use themselves as 'therapeutic tools', using and investing their real selves into the work. This left me wondering about potential risks associated with this. Although they experience having support and space for reflection, I can't help thinking that should they have a ' bad day' at work, this will feel a reflection of themselves and their abilities.

3rd October 2011 - Section A: an academic challenge

I was anxious about my meeting with Linda today as she was giving me feedback on my Section A draft. I felt great relief that she thinks the structure and the main parts of the content are promising. Everything seems to be falling in to place with that. I think that Section A may have been the most challenging piece of work that I have ever written. I have found the selection of relevant theory, and how this connects with the death of empirical literature, very difficult to structure, summarise and make sense of. There is a lot of work to do, but at least I know what areas I need to focus on update or swap around. I feel that this relief has greatly decreased the pressure for me and will allow me to focus on the rest of the analysis in a calmer and more confident way.

7th April 2012 – Start of Section B write up

There has been a long break since analysis, due to commitments with other course assignments. I have started to write up the results. But before I was able to start, I spent two days reassessing my themes. I realised there were still too many overarching themes, so have managed to combine some of them, reducing the number of overarching themes. This was a useful experience, because it allowed me to feel familiar with my data once more. Despite a reduction in master themes, it is very difficult to select which themes deserve more space. I want to do the data justice, but there does not seem to be enough space. I am pleased there is space to provide more extensive examples in the appendix. I have enjoyed including the verbatim quotes that I feel really capture the essence of the participants' experiences.

Appendix L: Extended Examples of Quotes

Where information has been omitted, blank square brackets were used [].

Pseudo names are used.

1.1 Reflection on group dynamics

Kevin: *So a lot of different things can occur but primarily it's about how our team is working, how we can support our team to work with the children as a whole, work with a child and its specific issue, um, to work with a network, how to clear up any conflicts.*

Janine: [] *so yeah you're doing the day-to-day care, but you are also trying to deal with the underlying emotional issues and the dynamics going on with the children, the impact that it has on staff as well.*

Janine: *So that gives a chance to realise 'oh I didn't realise that was having such an impact on you' or that you were struggling with that. [] If you pull it all together, it gives a much clearer picture of what's going on within the group as a whole.*

Shareese: *It's a very transparent place to work. Which at times can make it difficult, but for the most part we try and have the difficult discussions because the kids have those difficult discussions and so unless we are able to do that at an adult level and identify with the feelings that make it difficult for the children, then we are very hypocritical really. To make the children do it in group meetings, we should also be willing to do it. Even if it's difficult to be honest about our feelings and how other adults make us feel.*

Alesha: *That was really really disturbing cos the 14 year old girl, where I had missed all her psychotic behaviour, we were just holding on to her until she went back to a family. So me and her had a lovely time - we were like a couple of teenagers. I did her eyebrows, her nails, that was the relationship we had, because the work had been done. So I was helping hold on to her. But I didn't realise that she was being nice to me but horrible to other team members. She tried to split me off. Until someone named it for me, I was like shit yeah she has been doing that.*

Helen:*[] we talk about everything all the time, I mean it's one of the key things about being here - that we have a sequence of meetings - formal and less formal where we talk about our relationships with each other as adults and our relationships with the children and the children dynamics and the adult dynamics.*

1.2 Forums for open and honest reflection

Kevin: *We voice our own preoccupations at the start of that allowing each of us to highlight either personal or professional preoccupations that might get in the way of us engaging with the task of that meeting.*

Janine: *At the end of each shift we have debrief time. So we have space to reflect and to get things off our chest so that hopefully we're leaving the majority at work. And being able to kind of go home and have some space.*

Luke: *And we'll sit and talk about how we're feeling and how work is effecting us, our mind um and just try to acknowledge the underlying feelings or the possible difficulties with the work and within the group of adults. We try and be very honest and reflective I think at (removed: name of therapeutic establishment). I think it's helped a lot of issues that could have possibly stagnated into something worse than it needed to be. Um, so that's helpful.*

Shareese: *But every once in a while, you do need a break and it's quite good having that team of colleagues. There's at least 3 people on a shift and 'actually, I'm really struggling with that so can I go and be with these other children who are having a nice time over here and can you deal with (removed: child's name) as a team.'*

Ben: *I think the most important for the child to see that everyone that is involved in their world, communicates. That the information is shared openly and honestly.*

John: *Um, I think it's kind of ingrained from day 1. I was always told to ask for help, um and I personally think I'd rather ask for help than I would tell a kid something stupid. And then be back tracking and cock things up for them really. I rather do the right thing than just make it up as I go along.*

Alesha: *We adults communicate - you have to communicate. If you don't communicate, its not gonna work. So already in handover, you have looked at the shift plan. You've already know that we have to hold on to him.*

Helen: *Because we talk about everything all the time, I mean its one of the key things about being here - that we have a sequence of meetings - formal and less formal where we talk about our relationships with each other as adults and our relationships with the children and the children dynamics and the adult dynamics.*

Helen: *So I think we are in this culture that is happy to.. and its… unspoken and spoken and open and honest that you can talk about things that are embarrassing about your worries, or what's made you feel uncomfortable. Your not gonna be laughed at or dismissed because everyone else in that room will have had a different experience that has equally put them in those places.*

1.3 Individuals are part of a group

Karen: *They all keep to it so that is private to them and it obviously teaches them respect for each other.*

Kevin: *I've had to rely on, um, my own skills professionally as well as the team, my team as a house team in group living as well as the treatment team as far as the psychotherapy department, the family team, um and the class, and the shift with adults to think about how we as a collective can provide enough quality of relationship, um, and an intimacy of relationship that the child doesn't feel wholly dependent on me so that when I go off on shift they don't fall apart that other people can help them, can respond to their needs, can support them.*

Luke: *And you know, when the adults work as such a team, um, I think that really helps them, although they fight against it at first, I think it really helps them to realise that you know, all the adults are working together to help them.*

Alesha: *You have to move on. You can't dwell on it. Be angry with her. You are angry with her. You're disappointed. You speak to her in disappointment rather than anger. It's not only her home, It's everybody's home.*

Helen: *And we've got another little girl who was very badly sexually abused by her mum and so when she first came, her way of trying to interact would be to say 'will you lick me?' and pulling her knickers down , 'can you lick me?... I like you…you like me….lick me' and then she would chose certain adults to really focus that on. And that's yuck and wrong and OMG (sic) and all the rest of it. But through being around as a team, we could really make sense of that. And we could also teach the child that we would have to relate to her in different ways, you know.*

2.1 Therapeutic work occurs in the context of a secure attachment

Karen: *If I've been off, they will ask why I've not been here. It's quite funny but you do build a relationship with them. You know there little ways. It's intuition where you pick up on things.*

Kevin: *And so appreciating the value of a significant role model, and that the mother normally fulfils that role, and therefore our capacity to represent that or symbolise that in our work.*

Janine: *Um, (pause) it think it's just trust really, I mean I think (pause) I suppose when they start letting you in to their life, when they start opening up a bit more, um yeah trusting you to share more of themselves with, um, trusting you to keep them safe, yeah, seeking you out to spend time with you.*

Luke: *All these children have very disjointed attachments with their primary care givers, or what should have been. You have almost got to sort of adopt the role of the*

primary care giver and give them that sort of parental nurture that they never really had before, or couldn't get or, you know, or something that was completely warped or skewed that they thought was the right kind of care. And showing them, 'no, that wasn't right, this is what should have been happening' is, I think, quite paramount in a lot of the kids.

Shareese: *Essentially, for most of the children, when they first arrive, the level of violence is just off the chart. It's all very explosive. What we do is we figure out how to manage it, we look at their relationships.*

Ben: *Yeah and because you build that relationship with the child, they may let their defences down more, coz you do know that child and you do know where they've come from and you can start to predict when things are going to happen. And you can voice it to the child. They can internalise the verbal feedback.*

John: *There are certain things I do for certain kids. For example, I bring a newspaper into work for one kid and I make a point of throwing it on his bed. That's like one of the little things that you do, but I think broadly speaking, just being there to listen and show that not everyone is scary and horrible and gonna do them some harm and try and teach them and let them feel that they can have some positive attachments and feel less crap about themselves and can begin to form trusting relationships and allowing them the space to do that or even not do that even.*

Alesha: *So yeah so if something's happened or like the incidents with her. We say stay in bed this morning; we'll bring you some breakfast in bed on days like that. And they love it and need it.*

Helen: *I think we just offer consistent care, primary care, nurturing primary care needs. So it would be ok for us to wash a 12 year old girls hair, de nit it and uncomb it if she would let us.*

2.2 The importance of consistency and clear boundaries

Karen: *They need a certain amount of rules and some of these kids haven't had rules. I think the rules to start off with were something he didn't want, so yeah its good parenting really.*

Kevin: *I know that my being consistent matters so much to the children and I've seen the children struggle so much with inconsistency of adult relationships here, as well outside before they've got here, um to know the benefit of not being, um so rigid that I can't adapt, that I can't be sensitive to the circumstances, but being consistent so the children I will always respond to certain things in certain ways,*

Janine: *I think it takes a lot of time with the young people we work with, cause obviously their attachment history is normally quite unstable or insecure, um but I think it's just being consistent - you know, when you say you're gonna do something, you do it. Sticking to the boundaries and the structures and routines that help them feel safe. Even though they go against it initially. You know, all of the young people at some stage tend to test you out when they come in.*

John: *Patience, a lot of time, a lot of understanding, a lot of being listened to acted upon, rather than just being listened to. Um, so you can have some control over their lives, which obviously they have never had before. A lot of people who care for them, and are there to pick up the pieces regularly, um, a lot of kindness.*

Alesha: *this is what we do, regardless of anything else that's going on in your life, - its only slippers at the end of the day, but it's the symbolic thing that is has - that's what we do.*

3.1 Working with psychodynamic concepts, eg., projection and transference

Janine: *I mean emotionally it can also have huge impact coz you're working with such damaged children. The projections, the transferences you're holding on to - if you don't have space to process that and get support I think you'd get emotional exhaustion.*

Janine: *I mean all of those things and I think it's working therapeutically as well, just having that understanding, the knowledge of the sort of therapeutic concepts as well. You've got them, they are all sort of tools that you can use to think ' what's going on here' and I think that's get alive in the team constantly. We all reflect in that way - thinking therapeutically about you know, what symbolic communication is happening, what underlying stuff and yeah, I think you just get into a way of working because yeah…[]*.

Luke: I'*m not sure how much support foster carers get in terms of the transference of the feelings being put on to them and what they can do about that, which is why its great we have such a therapeutic support system put in.*

Shareese: I*t's always been made very clear to us that 'your emotions are not completely controlled by you. There's transference and countertransference and dynamics within a group and if you don't verbally address them - sometimes you won't be able to. Sometimes its just not that clear, um then they will manifest in other areas and I think fundamentally everybody that works in such an environment thinks actually if you don't take care of yourself then you contribute something that may not be positive for the kids.*

Ben: *Without that reflection, on the behaviours and the projected feelings, people would just leave. If you don't work in a therapeutic environment then you do get full*

of these feelings and they can be catalysts of a high staff turnover or high absence and low morale

John: *Transference, projection, splitting, paranoid-schizoid position, depressive position. I'm not just reeling off big words, cause I think I know them, um and then lots of stuff like attachment theory with Bowlby, Winnicott, and also quite a lot of the stuff was done from Bion and Group Theory - systemic theory where one week we did this particular group activity excersise.*

Alesha: *If you don't feel the transference, if you don't feel angry with these children sometimes, you know, or hate for these children sometimes, I don't think that you can do the work.*

3.2 Reflexivity/Working with two levels of consciousness

Janine: *Rather than getting caught up on the surface, you know, looking deeper, um, being able to empathise, being able to really immerse yourself in that young person's life without becoming, well, whilst being able to step away and reflect so that you can be useful for that young person, but so that they also feel that your standing alongside them and trying to understand.*

Shareese: *I think when I first came, I was very much willing to look after the children and it was more practical, kind of 'they need to be well looked after, clean their teeth, loved, adored and all those things. But I think, if I'm honest, I've learnt a lot from them and It's more about allowing the chaos to happen.*

John: *There is reflection, reaction in action - where something's thrown at you and you kind of deal with it then and there. And then afterwards you reflect on it and chat it out and try and find the more deeper understanding..*

Helen: *I can think, 'I'm at work, I can deal with this, and if I can't then I know X Y and Z are downstairs. I'm just going to ask them to swap'. So I can maintain.*

3.3 Behaviour understood as a communication

Kevin: *it's good that we've seen*[5]*it, it's good that they're trying to express themselves and communicate to us.*

Janine:*Um I mean sometimes it can feel personal, but I think it is remembering ' this isn't personal, this is actually what seems very threatening and your initial reaction might be to feel quite angry about it, but it's important to remember that this person must be feeling absolutely terrified…*

[5] 'it' refers to the childrens' challenging behaviour.

Luke: *One of the children that saw a lot of domestic violence for a long time, would demonstrate a lot of violence towards the women in the adult team. And so most of it has hints of their past in ways that they are sort of trying to communicate.*

Shareese: *That the child may not be able to understand and putting it in words that they can understand, so some of our children will pick up a chair and throw it and be very angry and it's just a case of saying, ' sometimes when I'm angry, I feel like doing that'.*

Ben: *I never think it's the child's fault, - you know, they've been born into that situation and the behaviours they are displaying are for a reason. You know, they are a form of communication.*

John: *But um a lot of it is essentially being understanding, patient, trying to figure out what's going on, looking at what they are shouting at you.*

Alesha: *Well knowing them, they tell you with their 'aura'. They can tell you that. I can walk in to a shift and if (removed: child's name) doesn't give me a hug as soon as I walk in that door, I know something's up.*

3.4 The inner world of the children

Kevin: *The rawness within that, their true potential, the horrible nightmares that they have and their terrible experiences being able to be explored sometimes for the first time and if we do our job well but probably more importantly if they let us, um then they take their wall down a bit or they open a window maybe in it, and let us in, in part or to a greater extent and we get to share their pain, come alongside and cry, to maybe just simply play with them a great deal and for them to internalise that they were worth it, that we valued them enough to want to spend two hours drawing with them or going for a walk with them or maybe you know a prolonged period of time whilst they were exuding every horrid feeling.*

Janine: *You know, if they show us their real rage and their real anger and all the nasty feelings they feel they've got inside them - will we come back and still be here in the morning? You know, not will you still be there but will you be there emotionally? Will you still want to spend time with them and be the same with them?*

Luke: *Generally the communication they give you they may be verbalising my dad did this to me or my dad or this woman did these things to me or I wasn't looked after in this way but it can also manifest in play activity with dolls. You see 2 dolls simulating intercourse or a rape scene. Things like that.*

Shareese: *A lot of our children come with coping mechanisms and the balance is to take away some of the coping mechanisms so they're not always on edge and tense and reactive and allowing them to be more comfortable and giving them different coping mechanisms without making them feel less worthy.*

Shareese: *I think a lot of our children are very insular and have had to be just to survive. And their reaction to situations is based on self-preservation. 'I don't know if*

it's a good idea to smile at you or not but the person that used to attack me - if I smiled at them they didn't. So if I smile at you, it's false.' But if you as an adult say, 'that's a really false smile' it doesn't compute. Whereas if you're angry, you can show me you're angry but you don't have to smile, because I know that you're angry.' And then the defences start to come down. Then the scaffolding has to go in immediately because they will just fall apart.

Ben: *My childhood was nothing like theirs so I have to really think what it must have been like to be that child and what they have been through in the first 6 years of their life is what I could probably take as an adult. It's sometimes hard to get down on that level of just how hard some things are.*

John: *Um and she's very damaged, she needs a lot of structure and routine in her day. She also equally is very manipulative, very intelligent young girl at times I think, despite how she presents. And yeah, she is very good at making me feel very mad.*

Alesha: *You have to know about what they've got planned and this particular girl has just stared to have unsupervised contact with her Mum. And her Mum still lives in the same area as her old stepdad, although they're not together and so to think she must be thinking ' god, I'm gonna go to the house, what if he's around? What if my mum can't cope with my behaviour? And her head must be all over the place for it.*

Helen: *I mean there is just the raw impact of them on you. It's huge. Their behaviour is outrageous, its shocking, the things they say - you can either hear it at a very 'la la I'm not listening' level or you can think about it ' oh my god, that is grim'*

4.1 Therapeutic carers value and have confidence in their role

Kevin: *I think when I started I just relied on common sense despite having done it before and learnt a bit about different theories at university and in other training at other establishments and coming here and being exposed to far more in-depth training and involved training then I think valuing experience and what we can learn from it just per se has been a revelation.*

Janine: *Well, luckily where we are, because of the support we get, I think that most people don't get to that point.*[6]

Luke: *So being able to come together as a collective and talk about how it's been I think is really important.*

Shareese: *Because there is an internal network of people, I think I can speak to anyone about anything. It's a very open space and people do say what they feel.*

Ben: *The (removed: name of community training scheme) then gave me the confidence to know the theories behind this, at the time I didn't know whether it was*

[6] "That point" refers to the point when a TCW feels like they want to leave the community.

Freud, Winnicott or Bion, or attachment theory. But now I have the academic understanding of what I have been witnessing.

Ben: *The biggest level of supervisions I appreciate, it at the end of a difficult shift. When you can sit down and reflect before you go home.*

Alesha: *I love process meetings.*

4.2 Emotional impact of the role

Kevin: *I like to have a laugh and so they cannot just enjoy my company but we can have fun with each other, they can play practical jokes on me, um, and I think I role model a really positive sense of slapstick and common sense humour*

Janine: *…so yeah…or just the moments where you are not just at the mercy of the emotional stuff and you're playing a game and you suddenly realise 'wow this is lovely' and everyone has a bit of respite for a while.*

Janine:*Um (smiles) its difficult, yeah its really difficult at times, it gets you in touch with things that you don't necessarily want to feel or even know about…*

Janine: *I have had children who have made me feel physically quite scared because with teenagers who can be bigger than me (laughs) you do feel quite threatened.*

Luke: *I think initially, it was very difficult to hear. What was being said due to the feelings of disbelief about how this could possibly happen to a child? For a while you try to sort of build up a bit of an outer shell towards it. Not desensitising yourself to it, per se, but making sure you are able to manage what the children are saying to you. Coz it's a lot of extreme, awful stuff you get told sometimes. Dwelling on it too much could affect people. And it has affected some people. Some adults at times.*

Luke: *When I first came here I had TBH not much of a clue what I was getting myself into. So the first time you see the children attacking and spitting and urinating through doors, it's just like 'my god, what's happening'. But I think, through experiencing it, you see it and know it and your able to realise where the anxiety is, you can see it building up and you have to think how you can stop it from happening, and calm them and the situation down.*

Shareese: *It can make you feel quite upset, it can sort of…you know, I say that my 45 minute drive home was my best therapy because I can sort of leave bits, some people live round the corner, I don't think I could do that.*

Ben: *I think the hardest thing we do is when we have a referral for a child and then we get all of their papers sent across. And then we read them and all the difficulties that they've had and you just have to distance yourself from what's happened in the*

past, and how historical some of that information is and then the child walks through the door.

John: *Yeah, I've been doing the job for about 9 months um its great fun to be honest with you, I like working with teenagers.*

Alesha: *It's a hard job and you do can go home with bruises and bites and spit in your hair.*

Helen: *So people have to come with a certain level of resilience and I think they have to be willing to use the support structures. There's loads of support available here but you have to act on it yourself.*

4.3 Investment of the self

Kevin: *It allows me and my colleagues to think about our own past, our own baggage, what we might be bringing to the work, and how that might affect how a child is with us or what we might symbolise for them because of how we might respond to their needs, how we might respond to them in relation to, when we've shared their experiences that they went through, whether we can empathise and relate or not.*

Kevin: *By providing myself as a safe and solid and reliable adult who cares for them genuinely rather than just for a pay packet []. Yeah I think just the more the young people trust you and the more you , yeah, the more of a relationship you gain with them, it becomes more of a two way thing, you know, you're willing to give a bit, they're willing to give a bit, that trust is established.*

Janine: *It's lovely going on the holidays with them um... yeah I mean the relationships stuff - just the day-to-day interacting with young people, when you have formed that relationship, even when you are together and you laugh and yeah, enjoy doing activities together and spending time together…um (pause)*

Luke: *Some people have found it quite difficult to continue the job. At times it can open up other people's past from their childhood.*

Luke: *I think ensuring that you don't let the work swamp your life. Um, ensuring you do go off shift and you can de-stress yourself and sort of get yourself into a different mind-frame. Or say your work mind-frame, as it were.*

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Shareese: *A lot of it is based on your own childhood and actually sometimes you kind of need to let that go a bit and go well, what happens if we do explore that?*

Ben: *My childhood was nothing like theirs so I have to really think what it must have been like to be that child and what they have been through in the first 6 years of their*

life is what I could probably take as an adult. It's sometimes hard to get down on that level of just how hard some things are.

Ben: *You know, if I go back to my Dad's house, there is a sense of dread that fills me even though I'm (removed: participant's age). It's a state that you will regress back to, so these children will always be reminded of stuff.*

Ben: *In my first few years, it was noted that I was taking time off at the beginning of January. It made me realise that the days I was having off were around the day my mum died or the funeral date. So actually now, I'm a lot better on reflecting on my sickness or why I may be sick. Its like, the day after I graduated, I had the day off with a dreadful migraine. I think it was a relief of passing, relief of my dad seeing me graduate coz he always said I was never good enough for college. It was everything and a way of my body just telling me to stop.*

Ben: *Sometimes I get criticised for talking about my family. But my family are a big part of me but they can see me as a genuine person. You have shared experiences and it can increase your empathy with them. Every adult brings something different because we are all individual.*

John: *Um there's part of it and I must admit until I started doing this work I wasn't particularly in touch with my feelings. I wouldn't ever describe or talk about my feelings or do things like that but now I have to be aware of them. I think I've grown a bit as a person for doing so but like yeah there is no way I could, otherwise I don't think you could build a relationship with anyone without showing some of who you are…[]*

Alesha: *So I am really honest with them and I speak about my family and my experiences. And my travels around the world. And it was all true, so if you say the same story again, it's exactly the same, its all true, I haven't made it up, I have told him before. I stick to that, I am myself with them, the adults. I just think it's really important to be real. Coz a lot of them can have periods of time when they are fake. And you know they're fake.*

Helen: *I'm playful, I enjoy their company. I enjoy being with them and just hanging out.*

5.1 Progress is individualised

Karen: *Yeah I mean one of the children was like a ferret. And if you could see his room now, its like clean and tidy, everything is in It's place, you just can't imagine the time invested in them actually changes them as people.*

Kevin: *Obviously its entirely individual dependent, and dependent on what they've come presenting but I've seen some children leave, not terribly different to how they've come and certainly we don't tend to be fixing children but we do aim and I think we do in the large part achieve giving children an increased emotional vocabulary and literacy. I think we are very, very good at allowing children the space to explore who they are and for them to shape that differently to the way it had been becoming shaped by their past experienced and by their past behaviours.*

Janine: *I suppose a moment where you see a pattern change in a child, or (pause) that sense of relief when a child…I don't know - let me think…when you have been through such a tough period with a child, and you see them coming out the other side feeling stronger, um them being able to ask and seek the support that is around them and um just the little achievements, you know, getting them into school each day.*

Janine: *It's different for every child. It's quite a difficult question to answer because it's so complex and it can be the smallest thing, or something quite big.*

Luke: *I mean, the key child I work with, um, when he first came he was feral to say the least. He was clawing, ripping at people's hair, getting through doorways via biting - whatever he could do. To see how far he's got now, I mean of course he's still got a lot of issues um but the difference in him now is so much more cohesive. The violence having almost stopped completely, it just makes you feel very proud to be part of a team that has achieved that with him. I think its great.*

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Ben: *The changes in the children are so gradual that actually, you don't sometimes reflect back on how far they've come. Its important to remind yourselves of that in the tricky times..*

John: *Um I think its sometimes hard to see the changes, obviously day-to-day there are small changes and that's part of all that reflective thinking, you kind of step back and see it. But just examples of kids who are doing things that you would never think they were capable of.*

Alesha: *He has been with us three months; he's come such a long way in three months. So it's growing. Our relationship is growing. If he sees me its hugs, hugs, hugs. And he doesn't try to dry hump me which he used to do at the beginning. Now it's a proper, I can feel it's a proper hug and I always say to him 'oh that was a lovely hug'.*

Helen: *Seeing (removed: child's name) who no longer pulls her pants down and asks staff to lick her vagina. So she now can go out a little bit wider and mix with the general public. She can get completely enraged now and I think people sometimes think that she has mental health issues as well, but she can become incredibly stressed and that used to go alongside incredibly vicious attacks - biting which would tear skin off, pulling out clumps of hair. Biting and hair pulling was her thing. And now she can just scream and scream and scream and scream and cry in a really grim way, but*

not attacking anybody. And then she reaches a point in that you can offer her a gentle help and take… so that feels positive because she was like a wild animal when she came. And she can have her hair washed and she can wash her own. And she can shower and bath on her own. And she needed to realise, internally herself that we wouldn't put her under water. Whereas when she first came, she didn't know that to be true.

5.2 Building resilience

Karen: *Maturity, talking, having conversations with people. It's that they can have that communication as apposed to a frustrating and angry mode. Just normal interactions that we take for granted.*

Kevin: *Yes, going for walks, going for bike rides, um watching films, chilling out, playing games of chess, um, listening to music, going for a drive, exploring, um providing children with experiences that might be daunting but they'll get a real sense of achievement from.*

Janine: *Um I think, hopefully, in the long run, we provide them with tools to deal with life in general - to deal with difficulties they will face throughout their life such as just helping them understanding that talking really helps or helping them understand that asking for help when you are struggling helps rather than coping all by yourself. And some of the coping strategies that they have developed, or defence mechanisms, that have been really useful at times when they have been in quite extreme situations, helping to recognise when they use them and when actually to let go of them, but having those resources there.*

Luke: *We try and help them get a feeling of helping them verbalise or being able to understand why it may have happened, how it made them feel, the possible reasons around it all, and how it might have effected them. And also what we can do to help them move on from that, in a sense.*

Ben: *That's why we give them lots of support - so they can function in the outside world.*

Ben: *It's just the basics really, that we all take for granted. Self-esteem and confidence. Being able to accept that things aren't always going to go your way. Being able to celebrate achievements, but hold on to them so when things don't go quite right, your whole world doesn't fall apart and you go back to square one.*

John: *Yeah, yeah it's the confidence to do things. But obviously a lot of undamaged kids have the confidence to do these things. Once these kids realise its not as big and scary as they think it is, with a helping hand, they can get there.*

Alesha: *He has just started having 20 minutes independence. They have just upped it so we will have to see how he gets on. But he doesn't go far. He just cycles to the end of the road. You can watch him from the house. Bless him. But he loves his independence. He has just started cycling to school. He loves it. It's brilliant.*

Alesha: *It would be so easy for them to come in and keep them sorted and happy for 5 years. And off they go and then that next person comes in. No, it's about getting them ready as much as you can.*

Helen: *She's not cured or fixed and she will need a life of support, but she's different to what she was when she came and I think that is a success.*

5.3 Discovery of a sense of self

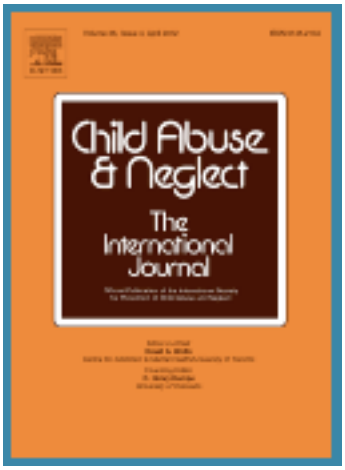
Luke: *I think making them feeling like children. A lot of these kids haven't had childhoods really. Its so awful - the kind of things that have happened to them and to let them, you know, feel like a child and play and do the things that children are supposed to do I think is paramount.*

Shareese: *Getting to know them I think. Each child arrives with a file - but getting to know them regardless.*

Shareese: *Just the sense of I'm somebody, I'm special and lots of people think that.*

Helen: *And so he can sense that whatever he suggests or feels is worthy so he doesn't have to be into other people's hobbies, he could quite be interested in his own drumming. And that would be good. That's fine to be interested in drumming. No one else in the house is interested in drumming.*

Appendix M: Publication Guidelines



Child Abuse and Neglect

The International Journal provides an international, multidisciplinary forum on all aspects of child abuse and neglect, with special emphasis on prevention and treatment; the scope extends further to all those aspects of life which either favor or hinder child development. While contributions will primarily be from the fields of psychology, psychiatry, social work, medicine, nursing, law enforcement, legislature, education, and anthropology, the Journal encourages the concerned lay individual and child-oriented advocate organizations to contribute.

Types of contributions

1. **Original, Theoretical, and Empirical Contributions (16-20 pages of text)**: Include a clear introductory statement of purpose; historical review when desirable; description of method and scope of observations; full presentation of the results; brief comment/discussion on the significance of the findings and any correlation with others in the literature; section on speculation and relevance or implications; summary in brief which may include discussion. Abstracts and references are required.

2. **Brief Communications**: Shorter articles of 5-7 pages (abstracts and/or references optional).

3. **Articles on Clinical Practice**: Case studies (but not single cases), commentaries, process and program descriptions, clinical audit and outcome studies, original clinical practice ideas for debate and argument.

4. **Invited Reviews**: Plans for proposed reviews are invited in draft outline in the first instance. The editors will commission reviews on specific topics. Reviews submitted without invitation or prior approval will be returned.

5. **Letters to the Editor**: Letters and responses pertaining to articles published in Child Abuse and Neglect or on issues relevant to the field, brief and to the point, should be prepared in the same style as other manuscripts.

6. **Announcements/Notices**: Events of national or international multidisciplinary interests are subject to editorial approval and must be submitted at least 8 months before they are to appear.

Contact details for submission

All correspondence, including notification of the Editor-in-Chief's decision and requests for revision, takes place by e-mail and via the Author's homepage, removing the need for a hard-copy paper trail.

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