

Residential child care and the psychodynamic approach; is it time to try again?

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Introduction

Therapeutic approaches to residential child care in the UK have been greatly influenced by the psychodynamic theories of D.W. Winnicott (1965), Klein (1998), Bowlby (1965) and Bion (1970), among others. The psychodynamic model of residential child care stresses the importance of understanding the emotional development of children and young people. It places particular significance on the anxieties and fears which arise for children when healthy emotional development is disrupted in early childhood. These theorists acknowledge a debt to the psychoanalytic theories of Sigmund Freud which he proffered as an explanation of human development and behaviour. Freud (1977) proposed that painful inner conflicts borne out of unresolved developmental issues during infancy, though repressed in the unconscious, struggle for expression in our conscious behaviour throughout our lives. These expressions coming as they do from the individual's unresolved infantile inner conflicts were, according to Freud, manifested in behaviours or defences which were socially harmful to the individual. Research such as the work done by Berridge and Brodie (1998) indicates that the vast majority of children in residential care have had early childhood disruptions or traumas such as physical or sexual abuse. Hence it would appear that this group of children could be helped by the use of psychodynamic approaches. Yet recent reviews such as that by

Maher (2003) seem to indicate that the influence of psychodynamic approaches on residential practice is on the wane.

This paper is based on the premise that psychodynamic approaches still have a great deal to offer residential child care and that the time has come for all involved in this work to look again at the potential of such practice. Following an examination of the historical reasons why these theories are resisted by the mainstream of residential child care, the paper will use a case study to illustrate the use of one particular psychodynamic approach, based on the work of Klein and Winnicott.

Psychodynamic approaches : a growing resistance

Ward et al. (2003) reported that psychodynamic approaches to residential child care have existed in Britain in one form or another since the 1920s, particularly in residential establishments which also offered education, such as Summerhill School and The Mulberry Bush. These establishments encouraged children to re-experience their childhood to help undo some of the damage done by their early childhood experiences. Following the *Social Work (Scotland) Act* (1968) and the *Children and Young Persons Act* (1969) (for England and Wales) the Approved Schools were re-named as Community Homes with Education in England and Wales, and List D Residential Schools in Scotland, and merged into the general child care provision.. This legislation offered an opportunity for a new generation of pioneers in the field of psychodynamic residential child care, such as Peper Harow School (Rose,1990).

From the 1980s, the psychodynamic approach came under critical scrutiny. *Lost in Care*, one of a group of influential child care research studies published in the 1980s, concluded that residential care tended to isolate young people from their families (Millham, Bullock, Hosie and Hack, 1986). This criticism was linked to the geographic isolation of many homes. A number of these homes were therapeutic communities for children and young people based on psychodynamic principles. Research indicated that these homes were rarely accessible to the parents of children residing in them and it was argued that this made the re-unification of families impracticable (Millham et al, 1986). The research signalled the era of locally based children's homes and marked the beginning of a trend which saw fewer children placed in residential care while more were placed with foster families. This trend continues to the present decade (Crimmens and Pitt, 2003).

The 1990s saw the beginning of another trend which has had implications for children in care. This was the development of a symbiotic relationship between electorate and government which increasingly sought instant and finite solutions to societal problems where more emphasis was placed on defensive professional practice rather than on relationships (DoH, 1998). The policy initiatives of the Thatcher government introduced concepts such as value-for-money and cost effectiveness into the social care arena. These initiatives have continued in subsequent governments. The over-riding political ideology demanded that care providers attend to performance indicators, outcome measures and target setting to provide justification for their funding. For example, the Audit Scotland follow-up report (2003) on dealing with young offenders stated that more attention needs to be paid to 'evaluating the cost effectiveness of residential schools and secure units.' (2003, p. 3) It also

highlighted the importance of performance indicators, saying that ‘The Scottish Executive should publish annual reports on performance of youth justice teams against national standards.’ (2003, p. 5) Dobson and Khatri (2000) argue that as society moves toward evidence-based practice and as litigation becomes more prevalent, then the need for interventions to have clear evidential support becomes more exigent. In such a climate, child care based on psychodynamic practice with its emphasis on taking time to reflect on and to ‘work through’ emotional problems can hold limited attraction, and there has followed an inexorable drive towards seeking time-limited solutions using what are seen as evidenced-based outcomes of interventions such as cognitive-behavioural techniques. Cognitive-behavioural interventions lend themselves to clear descriptive and outcome measures. Stevens (2004), however, raised questions about the real nature of the evidence provided by research on the use of cognitive-behavioural interventions in residential child care.

The current decade has seen the growth of risk assessment in residential child care. While this is aimed at protecting children, it could be argued that it can also act as a straightjacket on the relationship between child and worker. The development of National Minimum Standards (DoH, 2002) while laudable, may reduce holistic care to a discrete set of criteria. In this atmosphere the ‘whole person’ approach of the psychodynamic ethos – that is working with the unconscious as well as the conscious - has struggled to flourish. It seems pertinent here to consider the influence of the group on the therapeutic relationship between a young person and residential child care staff. If this relationship is to flourish, then during the delicate time when it is being established, the young person and the worker need to be emotionally held by the other young people and staff who make up the group of people involved in the life

of the children's home. Yet current thinking about residential child care does not acknowledge the significance of the group. For example, the National Minimum Standards make no reference to aspects of group living. Equally the mandatory units of S/NVQ level three Health and Social Care (Children and Young People), the required minimum qualification for residential child care workers, make little reference to group living. While it appears that the need for professional commitment to establish and sustain healing relationships in a group living setting is not a priority for those charged with strategic planning in residential child care, it is my contention that psychodynamic approaches still have much to offer.

Applying a psychodynamic approach to residential child care

For the purposes of this paper, the theories of Klein and Winnicott are used to analyse the case study of Roland. Klein placed great emphasis on the infant's relationship with the primary mothering figure. At first totally dependent on this figure, the infant, in 'phantasy' (*Klein's spelling*) splits the mother into the good mother who is present and able to provide continuous nurture, and the bad, absent mother who is not providing nurture. The infant finds the latter situation intolerable and cries out with distressed feelings of terror and fear of abandonment. This is what Klein called the 'paranoid-schizoid position'. To resolve the infant's distress, the mothering figure absorbs her infant's unbearable feelings and returns them to the child in a form that they can accept. The infant eventually becomes able to unify the good and bad mother and to realise that although the mothering figure may not provide continuously, she will return. Once the infant has reached this stage of acceptance, he or she is said to have moved from the 'paranoid-schizoid position' to the 'depressive

position' from which the infant has the psychological basis to deal with what life holds. Klein thought that children who experienced inconsistent and unsatisfactory nurturing had great difficulty in making any satisfactory progress towards the 'depressive position.' She believed these children were emotionally ill-equipped to deal with the vicissitudes of life and remained in constant fear of being abandoned (Klein, 1998). Winnicott, drawing on Kleinian theory, believed that while the infant needed consistent parenting care, it should not be perfect care. According to Winnicott, satisfactory parenting figures, though human and capable of mistakes, offered care which was 'good enough'. If the child was cared for by a parenting figure who was ideal, rather than real, then they would be ill-equipped to deal with the imperfect world. 'Good enough' parenting figures provided what Winnicott called 'the facilitating environment': a stable physical and emotional environment where the child was safe and yet allowed sufficient emotional space to grow in a way which enabled him or her to build healthy trusting relationships and so become resilient enough to deal with life's experiences (Winnicott, 1965).

It is this 'good enough' parenting and the 'facilitating environment' which those who work psychodynamically in residential child care are attempting to re-create for the children they look after. All too often the young people placed in residential child care have not experienced the nurture required to progress from the paranoid-schizoid position to the depressive position. In Winnicottian terms they have either not been provided with good enough parenting or they have, in another category which Winnicott described, experienced good enough parenting which has been traumatically interrupted as a consequence of a change in family circumstances or as a consequence of emotional, physical or sexual abuse (Winnicott, 1965).

Achieving the 'facilitating environment' is a time-consuming and complex task and has implications for the training of residential child care staff. Residential child care workers need to be aware of the significance of 'transference.' Unhappy children entering a unit often express the fears and frustrations of their past by acting out. It can seem as if they hold residential workers responsible for all the emotional ills they are experiencing. In this they may be unconsciously 'transferring' on to the care worker feelings which relate to previous carers who are usually their parents (Rycroft, 1968). The worker, like the 'good enough' parent, processes the child's feelings and returns them in a way which they can tolerate. The unit becomes a place where painful emotions can be held safely while progress is made towards a more healthy emotional developmental stage. (Winnicott, 1971).

The residential child care worker must also be alive to the primitive infantile anxieties which a young person's behaviour can arouse in the worker herself. This is known as 'counter-transference' (Heimann, 1960). It is essential that residential child care workers do not act out their counter-transferential anxieties by responding to children in superficial authoritarian ways. Instead they should reflect on the feelings the child has aroused in them in order to gain a clearer understanding of how the child is feeling. Again, like the 'good enough' parent, the worker processes these feelings and gives them back to the child in a way that will re-assure him.

Roland : a case study in the application of psychodynamic principles

Roland was a child who was received into care in 1994 and admitted to a small mainstream children's home in 2003. The issues in Roland's case are described in the words of the children's home's manager. After this description, an analysis of the case study will be given, showing how a psychodynamic approach was used to help Roland.

Roland was removed from the family home at the age of 4 because his parents were unable to care for him due to their chronic alcoholism and frequent episodes of domestic violence. He had had two foster family placements before he came to our children's home at the age of thirteen. His previous placements had broken down because his carers said that they could not cope with his violent behaviour. Roland was a very angry young man who did not trust adults and was particularly angry at social services whom he blamed for taking him away from his parents.

When he arrived at our home, the staff decided that before his presenting behaviour could be addressed he needed a period of holding and containing. He could then be helped to look at the anger generated by his denial of his parents' inability to care for him and to think about the splitting off of his angry feelings on to those people he held responsible for his removal from his family. The recipients of these feelings were Roland's social worker and the staff of our children's home.

Our task was to gain an insight into Roland's inner world. We had to understand how he was feeling so that we could help him to get in touch with the emotions that made him angry. We also had to help him to make sense of his denial that his parents were unable to care for him. He could not at this time cope with the

knowledge that the two people he most idealised were flawed. This part of him was stuck emotionally at the four-year-old youngster who had been taken away from his home. He had been led to believe by his parents that the only reason he could not live with them was that social services had unreasonably removed him from them.

Roland's anger and violent behaviour led staff to question themselves and doubts began to surface about the efficacy of psychodynamic notions of containment and holding. He disliked taking part in activities with the group. In spite of this, the group supported him. At times staff themselves became dysfunctional when faced with the power of Roland's projection of fear, anxiety, hopelessness and, above all else, displaced anger. Before beginning to help Roland to make sense of these overpowering feelings, the staff first had to make sense of how the powerful emotions projected by Roland were affecting them. They had to come to terms with their own anger at Roland's parents and also the inner anger they felt about Roland because of his difficult behaviour. They also had to manage their feelings of helplessness because they were aware of the main cause of Roland's unhappiness and felt powerless to do anything about it. As Roland's acting out became more difficult to cope with, staff, sometimes consciously, sometimes unconsciously, resorted to behaviourist strategies in order to convince themselves that they were in control. Effective management input and good supervision helped to contain and hold staff and encourage them to stay with the psychodynamic approach.

Our children's home is close to the young people's families and communities. We encouraged visits to Roland's family to get in touch with his real feelings about their inability to care for him. With the support of his keyworker, Roland began to understand the reality of his parents' situation. This was a painful emotional journey but it enabled Roland to develop and test coping strategies which eventually helped him gain confidence.

He became able to voice the opinion that the care he received from his parents when he visited the family was not in the qualitative sense good enough for him. He became able to leave the family home when he felt unable to cope. Though it brought him sadness, he reached his own understanding of why he could not return home more permanently. Today Roland still visits his parents but he now has sufficient control to ensure his safety. The pain and anger are still there but through confronting them with the help of the staff team, he is better able to order his inner world and respond in more socially appropriate ways.

Analysis of the Case Study

To avoid confusion, the child is referred to as 'he', while the residential worker is referred to as 'she'. Roland raised anxieties for the staff group as well the other young people. Kleinian theory related to the paranoid-schizoid and depressive positions reinforced the importance of the workers' need to be aware of and reflect upon not only the anxieties of the young people but also their own anxieties. By being aware that their own primitive infantile anxieties were being aroused, they were able to contain them and so contain Roland's anxieties. It is clear that at the start of his placement Roland was in the paranoid-schizoid position. Roland's 'phantasy' was that

the staff, like his parents and other previous carers, would not look after him and would abandon him. He expressed his fears by acting out in a regressive way and unconsciously ‘transferred’ these angry feelings to the residential workers. The staff’s understanding of this process provided Roland with a mental space, ‘a facilitating environment’, which allowed him to regress safely to where his emotional development had been arrested by unhappy events in his earlier childhood. Roland’s positive developmental progress could be measured by his gradual acceptance of the reality of his parents’ situation and his trust that, with the staff’s help and his growing self-understanding, he would survive.

Psychodynamic theory tells us that each individual has relationships within an inner world as well as a relationship with the external world. It suggests that many of our fears and anxieties are representations of unconscious inner conflicts which are too painful for our conscious to bear, yet we are trying to resolve these inner conflicts as we try to cope with our external environment. Bion (1970) has argued that group living can offer its members the opportunity to give expression to their inner conflicts, at same time as being emotionally contained by the group. In Roland’s case this was evident in the way the group was able to contain his unhappiness (which was expressed through the defences of angry and aggressive behaviour) as he worked through the loss of his idealistic fantasies of his parents until he was able to accept the reality of their frailties as human beings.

Roland’s symptoms were not only contained by the residential staff, but also by those youngsters within the group who, though sometimes the targets of Roland’s acting out, were more closely situated to Klein’s ‘depressive position’ and further

through the therapeutic process. They were able to re-assure him that he would neither be blamed for any dysfunction of the group nor rejected in the way he had been from his parental home and previous foster homes. The resident group received insightful and intensive support from staff and the home's manager to ensure that both they and Roland were protected from his acting out behaviour.

Discussion

If staff are to work with the emotional and intellectual intensity which those looking after Roland were attempting to achieve, then there are implications for the recruitment, management and training of staff. Working psychodynamically is complex and requires staff to have both intellectual and emotional insight into what makes a relationship. This can only be achieved with self-challenging training and supervision. The resource implications of this may in part explain why those responsible for the management of caring services resist the psychodynamic approach.

Human beings do not necessarily fit into prescribed categories or to prescribed short-term and narrow treatment programmes. Yet it can seem that the wider community has a need for something to be seen to be "done". Short-term finite solutions can be a dubious panacea which gratifies an unacknowledged general need of the wider community to feel that it is in control of troubled young people. The other side of this coin is the unconscious infantile terror of being out of control. Acting out this societal 'counter-transference' achieves as little in the wider community as it does in the smaller world of the children's home. For staff in the unit, it can seem that the communities responsible for placing young people have decided

that they can do nothing else with them. In this extreme situation, psychodynamic approaches offer staff the idea that there are times when it is better that nothing is 'done' to or for a troubled young person apart from providing the space to heal.

Waddell (1985) examines the different stances adopted by social workers and psychodynamically-trained workers. She argues that the psychodynamic worker attempts to create a mental as well as a physical place, where time is given for young people and adult carers to reflect and have a space where it is *safe not to know*, (my italics) and room to process what is happening in their relationships. I would suggest in the current social work and residential child care cultures, such an approach is not valued because it is not seen as specifically 'doing' anything and so challenges the 'finite solution' way of thinking. Waddell reminds us that this kind of 'doing' - always having a ready answer - is more about 'servicing' a system rather than 'serving' a young person.

A fundamental premise of the National Minimum Standards is that good residential child care must be based on the development of a stable, trusting relationship between a young person and a caring adult (DoH, 2002). A relationship of this kind is fundamental to the psychodynamic approach. Making a relationship is complex and time-consuming. It is a process which requires commitment from both parties if it is to be real. It needs time and space for reflection, particularly when difficulties occur. While the S/NVQs relevant to residential child care discuss relationships, they can read as if a relationship is something that is 'done' to looked-after children rather than an acknowledgment of the mutuality of a relationship. The training of residential staff, while encouraging a reflection on the importance of

relationships, could do better by exploring these as complex mutualities which alter the behaviour of both parties. It could be that some placement breakdowns in children's homes are exacerbated by staff who may not be trained to deal *emotionally* with the behaviour of children. This view has some empirical support in the research of Heron and Chakrabati (2003). They explored the perceptions of staff towards children in residential units and found that rather than empowering residential child care staff in developing their relationships with young people, those who drive current developments in social work de-prioritise the needs of children by failing to provide staff with training which addresses the real issues and problems, in particular the relationship between child and worker.

Conclusion

It is all too easy to criticise a social work system where local authorities are 'driven by twin imperatives: the need to manage increasing levels of need and expectation within generally static or diminishing budgets and a need to avoid unacceptable levels of risk' (Maher, 2003, p. 279). Nonetheless, while residential child care remains a significant resource, we, the adults involved in residential work, should be able to acknowledge both intellectually and emotionally what is happening in residential child care and begin to imagine how we can provide troubled young people with the time and space they need if they are to be helped to grow in a healthy way. I believe that relationships in residential child care informed by psychodynamic principles can be a creative force in achieving this.

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