

*‘The paradox of living
with the unknown’*

*The Mulberry Bush School: an
exploration of how a therapeutic
approach to looking after emotionally
traumatised children affects their
capacity to develop relationships, and
to understand and regulate their
feelings and behaviour.*

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of Philosophy (PhD)**

I, David Roberts, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed.....

Date...25th March 2020

Abstract

The impact of early-life trauma on young children should not be underestimated, nor the impact of living and working alongside these children. This study is concerned with how a therapeutic residential special school affects primary-aged children who have experienced early-life trauma. The therapeutic environment focusses on building relationships as a way to support the children to understand and manage their impulsive behaviours.

This study makes an original contribution to the field of therapeutic residential childcare, looking at how a psychodynamically informed model, underpinned by group work, affects children and their families. The study employed a case study approach, focussing on the Mulberry Bush School and its therapeutic approach to care, with the cases of four children forming embedded units. Seven interviews per child were undertaken over an 18-month period, supported by observations and documentation. Psychodynamic and reflective practice approaches were adopted for the analysis and discussion of the evidence.

The analysis found that the therapeutic environment positively affects the children's ability to understand their feelings, leading to more positive relationships and improvements in behaviour. However, the analysis also identified significant variation in expectations about child placements and their benefits, with many of the staff having expectations of emotional development that exceeded what the children had the potential to display. Despite many positive outcomes, how these were achieved was often poorly articulated and misunderstood. In part, this may be understood as a defence against their experiences of emotional trauma, which paradoxically leads to increased levels of anxiety among children, families and staff. This highlights training and organisational implications for the school, and more widely for the therapeutic childcare sector.

This research makes an original contribution to the existing knowledge about the therapeutic approaches used for looking after children who have experienced early-life trauma. The conclusions from this thesis have implications not only for the Mulberry Bush School – the organisation and its training provision – but also for the therapeutic childcare sector as a whole.

"It's a lie to think you're not good enough, it's a lie to think you're not worth anything."

(Nick Vujicic)

Impact Statement

With the rise in children experiencing complex trauma, this study gives a voice to children, their families and staff working in a residential therapeutic special school. It is hoped their comments may inform future practitioners and policy-makers. The study addresses the gap that exists in understanding the therapeutic approach and the effect it has on children who have experienced trauma. It seeks to contribute to a better understanding, intending to benefit the childcare sector.

The case study reveals a number of areas of practice that require further clarification. Addressing these will increase opportunities to develop what the therapeutic approach can offer children. The analysis draws upon features that enable children to benefit from the therapeutic approach, exploring how this affects their ability to develop and maintain relationships. These approaches, such as the use of group work, have the potential to impact practice in other non-residential settings, such as schools.

The study could contribute to the field of therapeutic residential childcare, particularly providing a detailed understanding of some of the barriers to the approach having a greater impact on children and their families.

Within academia, the study offers a robust understanding of the impact of childhood trauma and how psychodynamic theories, supplemented by other theories, can help us to understand children and their families. This understanding should be used to implement staff training initiatives across the childcare sector and complement further research into the impact of trauma on children.

As a professional trainer and university tutor, developing links between theory and practice is vital to supporting practitioners to understand the affect a therapeutic approach can have and how this could be developed. The primary case study provides an accessible, real-life analysis of working with children and their families. This understanding could extend practitioners' understanding of working with children and their families, and also have significant wider implications. These may include introducing working with trauma into training courses across the childcare sector, including education. Furthermore, the analysis offers policy-makers and commissioners' valuable insights into a therapeutic model, which could be considered to enhance other settings, such as education. The work on this thesis has already provided a beneficial discussion within the Mulberry Bush School, among staff, management and researchers, and is being introduced to the wider organisation with which the Mulberry Bush School is engaged.

The impact of this study should be brought about through the dissemination of scholarly articles and the development of practice guidance for staff working directly alongside children and families who have experienced trauma. The impact could be further enhanced through the presentation of the findings to researchers, policy-makers and commissioners within the sector.

The findings of the study may provide evidence for those in the UK in arguing their case for the use of a therapeutic approach to working with trauma, supporting the development of professionals who are equipped for working with the rise in childhood trauma.

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*“Perceived unknown by an eye that peers
from a hole in the tent where no one goes...”*

(David Bowie, 1968)

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Abbreviations and Acronyms

ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Service
CEO	Chief Executive Officer
COO	Chief Operating Officer
DfE	Department for Education
FC	Foster Carer
LAC	Looked After Children
MBS	Mulberry Bush School
PETT	Planned Environment Therapy Trust
TC	Therapeutic Community
TCC	Therapeutic Childcare
TCTC	The Consortium of Therapeutic Communities
UK	United Kingdom
USA	United States of America

Chapter One: Introduction

1.1 Introduction

This thesis is situated in the residential therapeutic childcare field, focussing on the educational and therapeutic work of a non-maintained special school for children who have experienced early-life trauma: the Mulberry Bush School (MBS) in Oxfordshire. I explore how the school's model of therapeutic childcare, underpinned by therapeutic community group-work principles, affects the lives and development of the children in its care, and their families.

This chapter sets out the study's background. I introduce the theoretical frameworks which underpin the study, before considering the contribution of the research to the field. Finally, I will outline the structure of the thesis.

Therapeutic childcare is not a new model for meeting the needs of emotionally traumatised children, but the phrase is probably more widely used today than at any other point in its history. However, attempts to establish the nature and extent of its effects are beset with difficulties. Efforts to assess children's cognitive, academic, emotional and social skills leave many struggling to determine whether children have made any progress, or even to define what might be considered 'progress'. The challenges are made more acute by the fact that many children in therapeutic settings present complex behaviours. The MBS's Chief Executive Officer argues that, for at least a minority of the children who have experienced early-life trauma, a therapeutic setting can best meet their needs (Diamond, 2013).¹

¹ Where sources are attributed to Mulberry Bush staff, these staff and their positions are given in appendix 8.

1.2 Rationale for the study

The introduction of the Children Act (1948) and the establishment of children departments in local authorities has led to an increased focus on the care provided for ‘disadvantaged’ children over the last 70 years. Rising assessment thresholds and reductions in provision have led to an increased number of disadvantaged children – many of whom have experienced early-life abuse, neglect and trauma (Biehal *et al.*, 2018) – being placed in out-of-home care. The population of neglected and abused children is considered the most disadvantaged in our society (CELCIS, 2016); their complex needs and challenging behaviour can lead to placement breakdowns, further affecting their educational, employment and relationship chances in later life (Action for Children, 2010). While precise UK data relating to the number of children who experience early-life trauma, including abuse and neglect, is not available, a US study suggests as many as 30% of children experience some form of childhood maltreatment (Hussey *et al.*, 2006). It is likely that the number of children with early-life trauma is increasing: 78,150 children were in care in March 2019 (Department for Education, 2019), a 12.5% increase since 2015.

Similarly, there are no exact figures for the number of therapeutic providers of childcare in the UK. In the 1950s and 1960s, evidence suggests the number was less than 20 (P.E.T.T, n.d.). The Consortium for Therapeutic Communities² (TCTC) now has at least 90 members, of which over 25 are UK-based children’s services, though other, non-TCTC therapeutic providers exist. Despite the increase in children in care and providers, far too little is known about the impact of therapeutic providers and their models of practice (Gallagher and Green, 2012). This study aims to fill a significant gap by contributing to an understanding of therapeutic work and looking at whether and how this approach affects children who have experienced trauma.

² An international, membership-based charity for all those connected with, interested in or involved in the delivery of relationship-based support in therapeutic communities.

The study aims to support the development of practice within the MBS and across the childcare sector as a whole, and to contribute to understanding how therapeutic settings affect children's lives. The use of appropriate research to underpin professional training and the design of models of intervention within the residential childcare sector is, at best, rare and more often viewed as a luxury than a standard aspect of good practice. This study will serve as a resource for organisations and practitioners to identify how children's behaviour, relationships and emotional growth are affected by therapeutic models. This should inform professional training programmes and support a change in the sector from 'intuitive practice' (Ward and McMahon, 1998) to a model which links 'research, theory and practice' (Turberville, 2018).

I undertook this study to identify elements of MBS provision that should be either endorsed or revised, and, evidence permitting, might be used in other childcare settings.

1.3 Research setting: The Mulberry Bush School

The MBS was founded in 1948³ by Barbara Dockar-Drysdale and her husband, Stephen. It has a long and established history as a nationwide resource for primary-aged children with histories of failure and rejection within educational, social and home contexts (Onions, 2017a).

MBS is a therapeutic, non-maintained, residential special school, with a purpose-built children's home since 2018. Up to 30 children from across England are placed for 38 weeks of the year at the school, though up to six of these children reside for 52 weeks in the children's home.⁴ Children are placed at the school by local authority social service and education departments, for up to three years. The first year allows the child and family to

³ Although there is evidence of admissions from at least 1947.

⁴ At the time of this study's data collection, the 52-week unit had yet to open, so this study focusses on children in the 38-week provision.

settle in and form relationships; the second year uses the safety of these relationships to undertake therapeutic work; the third year focusses on the child leaving the school, disengaging from their relationships and transitioning to their subsequent placement.

All MBS children have had adverse early-life experiences, which may include abuse, neglect or experiencing or witnessing violence (Harriss, Barlow *et al.*, 2008). Most children joining the MBS have an Adverse Childhood Experience (ACE) score⁵ of at least five out of ten, though some are as high as seven, suggesting extreme levels of early-life trauma. This has resulted in complex trauma, ambivalent and disorganised attachments and the breakdown of multiple previous placements, both family and educational.

1.3.1 History of the Mulberry Bush School

During World War Two, Dockar-Drysdale looked after a small group of deprived evacuee children in her home, first in southern Oxfordshire, then in rural Berkshire, before settling in the MBS's current site in West Oxfordshire in 1948. This move coincided with the Ministry of Education offering support to the MBS as part of a national programme that sought new hybrid models of child guidance clinics and special needs schools, such as the MBS, to meet the growing needs of displaced and emotionally troubled children (Diamond, 2018).

Compared to her own children, Dockar-Drysdale noticed differences in the children's behaviours and relationships, and although at that time unqualified in therapeutic work, she established links with experts in the field to help her make sense of her observations. Subsequently, she trained as an adult psychotherapist, working closely with eminent paediatrician and psychoanalyst Donald Winnicott in a long and fruitful collaboration whereby they conceptualised their treatment and approach to this child population (Reeves,

⁵ (Felitti, 1998) see appendix 7 for a fuller discussion of ACE scores.

2002). Ideas such as Winnicott's concept of emotional holding (1960) remain central to the school's work (Diamond, 2018).

Throughout the 1950s, 1960s and 1970s, Dockar-Drysdale developed her influential ideas, defining different syndromes of deprivation and developing treatment approaches. This included her 'most important work' (Bridgeland, 1971), defining the 'frozen child'⁶ and offering clinical vignettes from her work to illustrate ways of working with such children. She described ways of adapting the provision to meet the needs of the children, including localised regression exploring the development of a therapeutic environment, rather than relying on therapy within a psychoanalytic session.

During the 1970s and 1980s, the school started to be run as a therapeutic community,⁷ with a small staff team, many living on site. A full therapeutic community model was not adopted, as this was considered inappropriate for primary-aged children. For example, in an adult therapeutic community, most decisions – including membership of groups – are decided by community members. Such decisions are considered inappropriate for the emotional and chronological age and development of the children within the MBS. It was during this period that the school moved away from dependent relationships with a therapist, often Dockar-Drysdale herself, to a treatment model based on the community as a whole as the primary therapeutic input (TCTC, 2018). Dockar-Drysdale described the growth of the school as 'more like a living organism than an institutional organisation' (Dockar-Drysdale, 1993, p.xvi).

During this period, the school further developed its group-work model: children living and learning as part of a group. Engaging with the community is a central tenet of therapeutic community work and a core social task which underpins other forms of learning, including

⁶ Dockar-Drysdale used the phrase 'frozen child' to refer to unintegrated children who had not had good enough primary experiences, which had impacted their capacity to form relationships, leaving them 'emotionally frozen'.

⁷ Therapeutic communities are structured, psychologically informed environments where the social relationships, structure of the day and activities are all deliberately designed to help with health and well-being (TCTC, 2018).

classroom-based learning. The model offers empathic relationships through day-to-day routines. The intensity of these relationships, which can often reflect children's earlier emotional disturbance, is shared among the adult group, allowing a greater sense of emotional containment within a nurturing environment (Diamond, 2011).

Throughout the 1990s, the school's physical environment was significantly redeveloped and updated, moving away from dormitories, which had existed since the 1960s, to smaller households with individual bedrooms. During this period, a greater focus was placed on the work undertaken with children's families. Dockar-Drysdale and Winnicott had always recognised the importance of this work, but now the school developed a team of Family and Network Practitioners, to liaise with families and professional networks and to undertake specific therapeutic work with parents, families and carers (Browner and Onions, 2014).

Despite its 70-year history, the school continues to base its work on critical therapeutic community principles to 'enable young people to internalise (...) caring and empathic relationships within a nurturing and containing environment' (Diamond, 2013, p.132). It has expanded its charity services to include outreach and research, hosting the UK's most comprehensive therapeutic community archive (P.E.T.T, n.d.), while still maintaining the original school at its core. These services are intended to offer an integrated model of practice, research and training to other organisations, underpinned by the theory base used within the school (Turberville, 2018), and have allowed the school to 'flourish as a beacon of excellent practice' (Haigh, 2018, p.1).

1.3.2 Theoretical background to the school's approach

Throughout the MBS's history, much work has been done to develop the theory base that underpins its therapeutic work. The school has a long history of child psychoanalytic psychotherapy, but over time this model has been developed to synthesise other relevant

theories – including attachment theory, complex trauma, group relations, neuroscience and ideas drawn from therapeutic community, planned environment and milieu therapy (Diamond, 2013) – in order to develop the Mulberry Bush Approach (Turberville, 2018): the school's model of specialist therapeutic residential care, treatment and education. At the heart of this approach sit the school's three core principles: an informed psychodynamic approach, the development of a reflective culture across the whole organisation and collaborative working (Turberville, 2018).

1.4 Research questions

As this study has progressed, my research questions have developed in line with 'flexible design' (Robson, 2002). The purpose of this study is to explore the potential therapeutic effects of the MBS, to provide a rich understanding of the school's work. The core question epitomises my interest in the holistic therapeutic setting, rather than an intrinsic interest solely in the children within the study.

Core question:

How does the therapeutic approach of the Mulberry Bush School affect the capacity of emotionally traumatised pupils to understand and regulate their feelings and behaviour, and to develop relationships?

Subsidiary questions:

- I. What are the benefits associated with a therapeutic approach, and what are the limitations of any such approach?

<p>II. How does a 'group-work' model impact on the children's ability to develop relationships?</p> <p>III. How are changes to children's behaviour recognised by their families and staff?</p>

Table 1: Research questions

My core question highlights my intention to examine the broader impact of MBS's therapeutic approach, and to focus on 'emotional trauma', thereby excluding any cognitive difficulties some children may also experience. The question clearly states that it is the therapeutic – rather than purely residential – nature of the MBS that is being discussed.

The first subsidiary question focusses on the benefits and limitations of the model. The second and third subsidiary questions focus on the model of group work as a therapeutic practice, and how changes to children's behaviour are identified by different participants. These indicate my interest in the process of developing relationships.

1.5 Outline of the thesis

In chapter two, I critically review the literature relating to therapeutic childcare and more specifically locate the MBS study in a broader body of research. The chapter details the key terms and theories utilised, focussing on what the literature tells us about emotional trauma and how this is understood in the context of the school. The final section focusses on the broader framework of therapeutic work, looking at models from across the UK and overseas.

Chapter three presents the methodology and theoretical design of the research. The chapter will set out the choices I made concerning the design, the selection and use of case studies and my approach to data collection and analysis. It will present and explore some of the ethical considerations and how these impacted the study. Since the ethical issues are

particularly complex, a more in-depth discussion is provided in appendix 9.

Chapters four and five present the findings of the study. Chapter four will provide a detailed profile of the MBS, defining the structures and cultures which enable its work to take place. This chapter will also present the four children involved in the study: their characteristics and backgrounds and how their life journeys have led them to the MBS. This will allow for a comparison between the children's cases, while also recognising their individuality.

Chapter six will present my analysis of the findings and draw together themes from studying the children and the school. Using the theoretical frameworks presented earlier in this thesis, I will consider how the therapeutic approach affects the children. Similarities and differences in the findings will be examined in line with the research questions.

Finally, chapter seven reviews the aims of the research, considering the impact on the school and on practice across the therapeutic childcare sector. This chapter also evaluates the theoretical frameworks used throughout the study. The limitations of the study are discussed and areas of practice and future research are identified. It is hoped that the school, and perhaps the sector, will benefit from these recommendations, and the study will contribute to the field of residential therapeutic childcare.

1.6 Summary

In this chapter, I have outlined that therapeutic work is not new and its assessment can be challenging. I have introduced the overall research area: the impact of a therapeutic residential placement on primary-aged children who have experienced trauma. The research questions relate to the experiences of children placed at the school – their perceptions, and those of their families and staff team – and whether the school's therapeutic model meets

the children's needs. The study uses psychodynamic theory and reflective practice to make a significant contribution to the academic discussion within residential therapeutic childcare, a currently under-researched area. The first part of this is undertaken in the subsequent chapter, which reviews the literature relating to the study.

Chapter Two: Literature review

2.1 Introduction

In the previous chapter, I presented the background to the study. I identified a principal feature of the work: namely allowing children and families of the MBS to reflect on their relationships, thoughts and feelings. This will help to develop an understanding of how these influence children's behaviour in the context of a residential setting.

I now review the literature relating to my primary research question, 'How does the therapeutic approach of the Mulberry Bush School affect the capacity of emotionally traumatised pupils to understand and regulate their feelings and behaviour, and to develop relationships?' I first set out the search strategy and terms, before reviewing the literature on the MBS while introducing psychodynamic theory, emotional trauma, reflective practice, and group work as the theoretical models. Subsequently, I will review the literature on therapeutic residential childcare (TRC).

2.2 Methodology

The MBS was founded in 1948, so literature concerning the school has been reviewed from 1948 onwards. A narrower time frame of 1990 onwards was identified to review emotional trauma and TRC, due to these terms being more commonly used since that time, though theories from 1948 onwards have been referred to where they directly relate to the subject. With one exception, all reviewed materials have been peer reviewed.⁸

⁸ In relation to the Mulberry Bush School this exception is an edited collection of papers (Diamond, 2018) written by staff at the Mulberry Bush school to commemorate its 70th anniversary.

2.2.1 Search terms

Before the literature search began, terms were selected to combine significant words from the research question ('emotional trauma', 'children', 'relationships', 'MBS') and supplemented with related words ('therapeutic', 'residential'). An initial search of 'therapeutic childcare' highlighted minor differences between 'childcare' and 'child care', while 'adolescent' and 'young people' were removed as the word 'child' encompassed these words in the search. The search terms represent terminology used within the UK and USA to give access to a broader source of literature.

The terms 'post-traumatic trauma' and 'adult' were excluded, having returned a significant number of texts not considered directly related to this study.

Keywords: therapeutic childcare (child care), therapeutic work, therapeutic community, Mulberry Bush School (Organisation), emotional trauma, relationships, group work, residential.

2.2.2 Search strategy

Phase one of the review identified 28 relevant texts in the MBS staff library and, through tracing references, a further 24 texts were found. These were shared with experts in the field of therapeutic childcare to identify additional texts.

This process was followed by direct topic searching using databases, search engines, library catalogues and indexes. Initially, this focussed on UK literature, but this proved limiting, so the search was expanded to include international sources, predominately from Europe and the USA. Many of these sources reflected the political climates of the country of origin, and thus were insufficient other than to provide context.

The initial search tools used were:

- The Institute of Education/UCL and The University of the West of England libraries
- EBSCO (Academic Search Premier and Education Research Information Centre)
- OVID databases
- Social Care Online
- Social Policy and Practice
- PsychInfo
- Google Scholar

Having identified the first set of significant texts, reference lists were used to trace backwards and forwards for further research. The Web of Knowledge was of particular use, along with the *International Journal of Therapeutic Communities* and the *Journal of Social, Emotional & Behavioural Difficulties* (SEBDA).

Online dissertation databases identified three relevant qualitative studies whose reference lists identified a limited number of new texts, indicating that saturation point had been reached. Three medical databases were accessed: BNI, CINAHL and MedLine. However, the texts returned were considered too vague for the research question. Research blogs and social network sites were also accessed and helped to provide a broader context of sources, though were not explicitly used.

Texts were sorted and graded in terms of relevance to the research question, with the final review of literature consisting of 84 texts. These were analysed to identify issues that characterise the field and categorised under three headings: the MBS, emotional trauma and TRC.

2.3 The Mulberry Bush School

2.3.1 Model of therapeutic work

The MBS's primary task is 'to help primary-aged children who have been unable to live in a family or learn in school, who have deep and complex emotional troubles and have developed antisocial ways of being, to discover helpful ways of living with themselves and others and to see themselves as learners and achievers' (Mulberry Bush, 2013).

The Mulberry Bush Treatment Model (Turberville, 2013) operationalises the three core principles discussed in chapter one and establishes a developmental thought process for its work. The model embodies the five critical elements outlined by Rex Haigh in his paper 'The quintessence of a therapeutic environment' (2013):

- Attachment
- Containment
- Communication
- Involvement
- Agency

These subsequently inform the school's 11 Key Elements: the identified areas in which children should make progress (Mulberry Bush, 2013), which include 'build[ing] healthy and mutually trusting relationships', thus relating to this study's research questions. While these principles are individually well articulated, it is less clear how they complement one another to form one approach.

Despite a 70-year history, there remains limited insight into the effectiveness of the school's approach and how these core principles impact the interventions with children and families.

2.3.2 *The Mulberry Bush School*

The most notable writers to have discussed the MBS include Dockar-Drysdale (1968, 1973, 1990), the school's founder, Reeves (2001), a former consultant and principal of the school, and Diamond (2018, 2015, 2013, 2012, 2011, 2009a, 2005, 2004, 2003), the school's current CEO. At the heart of these first-hand working perspectives sits the core belief that it is the therapeutic relationship which needs to be considered and developed. This directly underpins not only the school's work but also this study's research questions. However, while these authors offer valuable insights into the school's work, I recognise that, as members of the school, they cannot be treated as impartial commentators. The authors all aim for objectivity in their work, yet the advantage of their writing is the in-depth experience they bring to their work. Inevitably this raises the issue of vested interests, potentially at an unconscious level. Consideration should be given to whether the authors may be disinclined to rigorously pursue challenging or unwelcome findings which might conflict with their own preferred history and theory of the school's work. None of the writers have discussed attempts to reduce the subjectivity of their work – for example, none refer to a phenomenological approach, which Guest *et al.* (2012) refers to as 'going beyond that of "experience" and states'. It is precisely this issue of reducing bias and maintaining objectivity which I have striven to work towards throughout this study – this is discussed in chapter three's methodology. For ease of reading, a list of staff sources used, and their respective roles, is provided in appendix 8.

Dockar-Drysdale's work (1968, 1973, 1990) is the most cited pre-1990s literature describing the principles and methods of the MBS as a 'therapeutic treatment centre'. Throughout the 1950s–1980s Dockar-Drysdale published a series of influential papers, later collected in *Therapy in Child Care* (1968) and *Consultation in Child Care* (1973). These texts have become valuable in underpinning the work of the MBS, identifying specific deprivation

syndromes and corresponding treatment approaches, such as the 'frozen child' (Diamond, 2009). These papers provide valuable insight into the development of the school and its current practice, and also the wider field of TCC.

Dockar-Drysdale's papers also introduced important therapeutic ideas, such as the needs of the staff team and the management functions within a therapeutic setting. They identified the importance of giving attention to the dynamics within the staff team and between teams as a means to reflect upon and understand the dynamics and relationships within the child group. These ideas still underpin the current work of the MBS.

One consistent theme is the emphasis on relationships. Initially, the model of therapeutic work was distilled from close one-to-one relationships between significant staff – often Dockar-Drysdale herself – and individual children. Although there has been a move away from the 'focal therapist' and intense relationships, the work continues through the development of therapeutic alliances and consistent relationships. Only when the child can allow themselves to develop such relationships can they begin to internalise good experiences (Diamond, 2015). For this to happen, the child needs to experience a safe and containing environment and relationships which can tolerate their often unbearable feelings, allowing them to have a symbolic experience which can be felt to be 'real' and therefore internalised (Dockar-Drysdale, 1990).

However, as valuable as these texts are, they are often based on specific models of therapeutic intervention, some of which are no longer utilised due to developments in theoretical understanding – for example, neuroscientific developments. These interventions offer the view of someone immersed in deep relationships within a setting which has both evolved and been impacted by the external world. For example, the documentation shows a significant development in the size of the staff team, with staff no longer living onsite. These changes have been, in part, led by external changes in social policy and working

arrangements. Furthermore, Rollinson (2018), the current MBS chair of trustees, suggests that the characteristics of children placed at the school have also changed – for example, withdrawn and anxious children are rarely placed at the school now. Instead, places are offered to children with extreme levels of uncontained, often aggressive behaviour. There is virtually no reference to children’s aggression in Dockar-Drysdale’s early writings, whereas recent texts (Diamond, 2009; Klott, 2013) suggest physical aggression and violence are a common characteristic of the children.

Diamond (2018, 2015, 2013, 2012, 2011, 2009, 2005, 2004, 2003) has written extensively on the history and development of the school, discussing how the relationship between theory and practice informs current working. He uses Dockar-Drysdale’s work as a foundation for an evolving model of therapeutic work, specifically detailing a move from close dependent relationships with children to the group- work model (Diamond, 2013; Lindsay and Orton, 2011; Staines, 2017), which has necessitated a review of the emotional distance staff hold from the children (Diamond, 2004). While Dockar-Drysdale described intense, even dependent relationships (1968), Diamond (2015) describes staff more as ‘participant observers’, who use the team as a reference point for the work, thus holding a bounded distance to develop thinking space. What remains clear is that the role of relationships, both one-to-one and group-based, continues to be central to the school’s work. This balance between close relationships and bounded distance is evidenced in Cooper’s (2012) detailed account of the role and journey of a keyworker. This issue is also highlighted by Diamond’s (2004b) idea of emotional distance regulation. In this, he describes a model whereby staff are emotionally attuned to (i.e. able to recognise, understand and engage with) the emotional state of others, and to the child’s needs, matching Dockar-Drysdale’s writings four decades previously.

In more recent times, the school’s theoretical underpinning itself has developed to include concepts of milieu therapy (Onions and Browner, 2012), discussed in section 2.3.3, and

neuroscientific research related to attachment theory (Diamond, 2015), recognising that a '24-hour curriculum' is provided for children with severe attachment disorders (Diamond, 2013, p.133). The most recent literature predominantly focusses on the development of specific aspects of the therapeutic task and is, again, written by current employees, including Onions (2013), Klott (2013), Browner (2011) and Turberville (2018). Onions (2013) describes a move away from purely individual psychotherapy to a model encompassing a more extensive range of therapies, particularly those related to neuroscientific development involving regulation-based activities, such as drumming and yoga. Her work builds on the neuroscientific ideas of Perry (2009), who proposed that sensorimotor and repetitive, rhythmic, body-based activities can help organise early brainstem deficits by developing children's self-regulation.

This work links to Klott's (2013) discussion of the use of autogenic training to help maintain a balance between the activities of the two hemispheres of the brain, and suggests links between this model and Winnicott's idea of the 'holding environment' (1963b). Klott's work was based within the MBS and discussed his application of autogenic training to individual and group settings.

Klott describes how autogenic training can be used as a self-help technique in therapeutic settings, arguing that the technique is a beneficial addition to therapeutic community work, leading to children's increased self-awareness, self-control, self-reflection and ability to engage in broader forms of therapeutic provision. Autogenic training supports the development of self-reflection and self-awareness, suggesting a strong correlation with the MBS's therapeutic approach. The model focusses on children working with an autogenic trainer to develop 'formulas' or phrases they can use to aid their concentration. These are subsequently shared with the wider staff team to support the child, though the paper makes no reference to how other staff support the work.

However, a criticism of Klott's work would be that it lacks some validity: his discussion does not refer to a prescribed methodology and it is based on personal experience rather than being research-based. The intervention was carried out by Klott within formal autogenic training sessions with children, and while the paper suggests the technique can be applied to settings such as classrooms, there is limited evidence of this taking place. Although the work was clinically supervised within the MBS, there is no reference to it, beyond Klott's own descriptions, in any of the MBS literature. Although the research suggests autogenic training has been used successfully for several decades, it fails to separate autogenic therapy from other interventions within the therapeutic community.

This evolving therapeutic model within the MBS is again highlighted by Browner (2013), who discusses working with families as a crucial component of the task and vital to achieving good outcomes for the children. Browner highlights the correlation between working with families and the child's ability to form and sustain relationships. This links directly to this study's research questions, which explore the development of relationships and seek the views of families as a primary part of the therapeutic process. However, the paper is based on personal experience and anecdotal evidence, rather than being research-based. Many of these ideas were brought together in a book published by the school to commemorate its 70th anniversary (2018). The book presented a series of historical writings about the journey of the school and a series of contemporary papers about the school's current work and wider charitable services. Although the book offers an important account of the school's work – including ideas I have worked from – it was written by members of staff and published by the school, meaning it is not independent or peer reviewed, and thus it is not considered any further here.

The school has tried to situate itself at the forefront of therapeutic childcare, in part through commissioning and publishing external research. To date, this has included two longitudinal research studies. The first, conducted by Harris *et al.* (2008b), explored stakeholder

perspectives (including children, parents or carers and staff) regarding the benefits and difficulties of a residential treatment programme for children with emotional and behavioural difficulties. The study selected five children who had spent at least three years at the school and were due to leave, and used short (30–45-minute), semi-structured interviews with the participants. The interview data was supported by school files and reports for each child, before the data was analysed thematically.

The study suggested that the stakeholders had consistently positive perspectives. All stakeholders highlighted the children's increased capacity to deal with their painful feelings, which was understood to link to positive changes in their behaviour. Others identified increased self-esteem, awareness of others and the ability to develop relationships and engage with peers. However, several stakeholders also highlighted their concerns about having a group of children with similar difficulties all living and working together. Some parents felt children had developed new behaviours – for example, swearing – while some were disappointed by the lack of academic progress. The study concludes that the 'school has had a considerable impact on the quality of [the children's] lives, and those of their wider families' (Harris, Moli and Barlow, 2008, p.6). This study is important both as the MBS's first piece of externally commissioned research and due to its focus on stakeholder perspectives.

However, despite the positive outcomes, the study had a number of limitations. It captured the perspectives of only a small number of pupils, their families and staff at a single point in time, and due to time constraints, there was only one interview per child. Furthermore, as the case study focussed on children who were leaving or about to leave, no follow-up data was available about the longer-term effects of the children's placements. Also, the selection process involved identifying children who would have the ability to respond to interviews, meaning that wider generalisation to the school, or the wider population of children, is not possible.

The second study was a comprehensive, seven-year longitudinal study and evaluation of the school's provision, undertaken by the UCL Institute of Education (IoE) (Gutman *et al.*, 2018) and linked to the school's 11 Key Elements. The study followed four cohorts of children, each for a consecutive three-year period, and used a sample of 36 children (23 boys, 13 girls). Of the cohort, 13 resided with birth families, 14 with foster carers, six were adopted and three were in other residential settings.

The study explored two main questions:

- Are there differences in the children's profiles according to their socio-demographic characteristics and education status?
- Are there changes in the children's profiles during their time at the MBS? Do these changes vary according to socio-demographic and other characteristics?

These were investigated through a number of validated assessment tools, including Boxall Profiles, Story Stem Assessments Profiles (SSAPs), Academic Progress indicators and the school's own aggression and antisocial behaviour tracking assessment. The study's conclusions supported the findings of Harris, Moli and Barlow (2008), suggesting that, while at the MBS:

- Children make significant improvements in academic progress
- Children undergo significant emotional development
- Children are increasingly able to self-regulate their behaviour and emotions
- Children have significantly fewer incidents of aggression and antisocial behaviour

The study recognised that children arrive at the school with few academic attainments, and thus their achievements are deemed to be significant in the face of their exceptional disadvantages and challenges (Gutman *et al.*, 2018).

However, the evidence relating to the children's attachment style was more mixed, in part due to inconclusive or less obvious evidence. Although the study did not identify significant changes in children's attachment constructs, it was recognised that, given the level of early-life trauma, any development towards forming a secure attachment could be important. Overall, the study found significant evidence of the effectiveness of the MBS's therapeutic environment (Gutman *et al.*, 2018).

Although this was an independent, informative and beneficial study, it had a number of limitations. The researchers were dependent on the data provided to them by the school, and missing data was identified for each measure; while this does not invalidate the data, it does undermine the generalisability of the findings. Data was collected at set times following children's admission, which meant some data was collected at different points during the year, corresponding to the date of admission (Gutman *et al.*, 2018), meaning that some children in the same cohort had less data. Also, some children's placements were slightly shorter than the full three years – for example, where children were older on arrival – and some were longer. Furthermore, while the sample size is significant for the size of the school, it remains relatively small, reducing the likelihood of obtaining statistically significant results.

The UCL/loE longitudinal study was complemented by a qualitative study undertaken by the University of East London to help develop an understanding of how the longitudinal study outcomes were achieved. The study focussed on two main questions:

- How does the therapeutic environment at the MBS work?

- What is the model for engaging and assisting children who experience severe social, emotional and mental health difficulties?

As with the UCL/loE research, this study benefitted from being undertaken by a small team of researchers, offering a greater range of experiences and a broader skillset, as well as increased critical challenges from team members. This aided the reliability and objectiveness of the study. The study's methodological approach, over 15 months, included over 30 process-recorded observations, eight interviews with children preparing to leave the school, 13 front-line staff interviews, eight senior staff interviews and seven interviews with individuals from agencies using the school's services (Price *et al.*, 2018). A core dimension of the study was the use of naturalistic psychoanalytic observations – a strong experiential element that allowed researchers to connect with powerful and potentially distressing states of mind (Price *et al.*, 2018). These were supported using MBS publications about approaches to supporting traumatised children with social, emotional and behavioural difficulties, before observations and interviews were reflected upon and analysed.

This study identified five significant conclusions:

- The school's therapeutic approach is distinctive because it trains its staff to stay close to the children's feeling states, using reflection on feelings (their own and the children's) as a means to make sense of the children's inner lives and behaviour (directly relating to the aforementioned concept of behaviour as a communication and the MBS's core principle of psychodynamic thinking, whereby staff make sense of children's unconscious communication, in part, through reflecting on their feeling states).
- The school is distinctive in recognising that staff need a 'therapeutic milieu' of their own, providing a safe place to express their feelings and equipping them with robust training in self-reflection and reflection on the work.

- Staff attempt to provide mirroring and empathy, then gently challenge responses (in this context, mirroring is taken to refer to the reflection of the children by a consistent adult in order to develop their identity) (Menzies Lyth, 1988). Subsequently, they work towards explicit reflective thought about what has happened, before attempting to make sense of the experience with the child.
- ‘Shame’ and its management are important dynamics in the setting which warrant further reflection (this is explored in chapter six).
- The school has devised a model of group living (residential care) where there is a diffusion of the intensity and privacy of the intimate attachment bonds formed in an ordinary nuclear family. The open and public nature of life at the school provides emotional protection for children for whom the privacy and emotional intensity of the family home are overwhelming and threatening.

Psychoanalytically informed ‘close observation’ was central to the methodology, but this highlights a potential limitation with the study: it relies on the observer’s representation of ‘what has happened’. This limitation was minimised by the use of a research team and multiple observations, but it still requires consideration. A further criticism, discussed elsewhere in my own study, is the uncertainty of researchers interpreting unconscious dynamics, particularly outside the school setting. The study also acknowledges the limitation of the data analysis, which focusses on what adults provide for the children, rather than what their peers can offer (Price *et al.*, 2017).

Arguably, this study is more robust than the UCL/loE study due to the use of researcher observations and interviews rather than data provided by the school. However, the research was funded and overseen by the MBS.

The final study – a doctoral thesis by the school's child and adolescent psychotherapist, Dr Caryn Onions – focussed exclusively on the work of the MBS. This qualitative research studied the experiences of and impact on parents and carers during their child's first year at the school, including the relationship between parents, carers and the school.

The study started with a number of common factors: home relationships had reached breaking point; the child was not receiving an education; the input that families received had not helped them sufficiently to develop a better understanding of their child; parenting was not able to support the child to live in the community.

The qualitative study undertook semi-structured participant interviews with the parents and carers of seven children. Phase one interviews focussed on the reason for referral and the participants' experience of the child; phase two interviews reviewed their first year. Data was analysed using a comparative thematic analysis at two time points, as well as a secondary narrative analysis. The analysis identified that parents were crucial to the progress made by the children, but that they also needed specialist support to reflect on their parenting role and relationships (Onions, 2017a). The research highlighted the tensions which can arise between home and school, and the emotional impact this can have on working with families, children and professionals. The thesis documented the first systemic research of parents and carers within the school (Onions, 2017a), or within similar establishments. The thesis concluded:

- The MBS needs to enable foster carers to reflect on their parenting role and relationship with the child, through the development of a comprehensive introduction for parents and carers.
- Issues of co-parenting between MBS staff and foster carers/birth parents require the development of training for MBS staff.

- The school should be more proactive in engaging parents and carers at an early point of the placement.

The study further identified that there was a lack of understanding among parents and carers of the therapeutic work undertaken within the MBS, and that they were not supported sufficiently to understand and process the overwhelming feelings which arise from being alongside their child. The researcher proposed that the MBS provide reflective practice sessions to improve the ability of parents and carers to understand, and subsequently manage, their child. Onions (2017a) identified that the findings were only transferable to other residential settings with enough similar specific circumstances, but this is an issue with the uniqueness of the MBS, rather than the sample size.

Limitations of the study included a small sample size and the impact of insider research (Onions was employed as a child and adolescent psychotherapist within the school throughout the research). Both these limitations can also be attributed to this study, but, as outlined in chapter three, they are minimised through a rigorous methodology of two-layer thematic analysis, allowing for triangulation of the data. The participants of Onions' study were primarily female, and no adoptive children were included, both of which limit the breadth of the study. The interview approach broadly followed Onions' own clinical style of working, but a more 'researcher' approach may have provided more depth about the participants' experiences of being parented (Onions, 2017a).

In this thesis, I intend to extend and build on the evidence and insights that these studies offer.

2.3.3 *Planned environment therapy/milieu therapy*

Founded by Marjory Franklin in the 1930s, the concept of planned environment therapy can be viewed as an umbrella term, of which therapeutic community is perhaps the most common example. Franklin used the term to refer to the model of group-based living, using the environment and the relationships she developed while working with traumatised young people through the experimental Q Camps before the Second World War. By 1945, Franklin had published her influential paper 'The use and misuse of planned environment therapy', in which she detailed her ideas developed with, among others, David Wills, author of the influential *Spare the Child* (Wills, 1971), including books detailing the development of therapeutic residential childcare in the UK. The concept of planned environment therapy is based on the use of the total environment, including the range of relationships and everyday activities for the treatment of each child (Diamond, 2009). Arthur Barron, a central practitioner in the planned environment therapy movement throughout the 1950s–1970s, described it as the 'only method that provides a viable method and approach to the residential care and treatment of the maladjusted' (Bridgeland, 1971).

It is upon this model that Barbara Dockar-Drysdale, founder of the MBS, who had a working relationship with Franklin, developed the MBS as a therapeutic school (Diamond, 2009). The therapeutic approach and background of the school is based on a therapeutic community model whereby the children live as a group alongside the adults who help them with all aspects of their daily lives – this is 'planned environment' or 'milieu therapy'.⁹

Milieu therapy offers children an environment that aims to understand and make sense of their inner confusion, turmoil and pain. It allows children opportunities day-in and day-out to explore their inner world and its impact on their current lives and relationships (...). Milieu therapy has other jobs too: it

⁹ Planned environment therapy is also referred to, particularly in Northern Europe, as 'milieu-therapy', and the two phrases are understood to be interchangeable (Kornerup, 2012).

seeks to manage children's feelings on their behalf, to set clear limits and boundaries, to leave room for cooling off times, where the focus is not on feelings, and for building up an alternative internal world based on ordinary experiences and healthier relationships (Onions and Browner, 2012, p.148).

This type of approach uses living together, rather than just staying in the same place (Ward *et al.*, 2003), to treat the underlying causes of disturbance by working with young people to make sense of the origins of their difficulties. This is often done informally with the group, recognising the impact of the group on each young person and their impact upon others (Carter, 2010). Planned environment/milieu therapy is an example of what Winnicott referred to as the 'facilitating environment' (Winnicott, 1963a): the creation of an environment which enables the child's development, particularly the child who has experienced early-life emotional trauma. It is this environment which the MBS strives to offer.

A distinction needs to be made between 'therapy' and 'therapeutic environment', as both terms are used throughout the literature, and this study primarily focusses on the term 'therapeutic'. For this study, 'in therapy' is taken to refer to a child having regular individual sessions with a qualified therapist¹⁰ who attempts to create a relational environment in which to build the child's confidence to explore their inner world. The term 'therapeutic environment' refers to a wider community setting with a therapeutic ethos, discussed in more detail in section 2.6. 'Therapeutic environment' refers to a model of approach, rather than an identified person/time for intervention. It is noted that not all children within the MBS have 'individual therapy', but all are part of the 'therapeutic environment' (Onions, 2013). The use of a therapeutic environment may be less intense for some children, yet broader in that it is a 24-hour-a-day approach.

¹⁰ Individual therapy may include drama, play, art, music or psychotherapy, but does not include speech and language therapy (SALT), which is viewed as education-based rather than mental health-based.

2.4 A psychodynamic way of thinking

A core principle of the MBS's work is the use of psychodynamic theory. This is used throughout the analysis of this study's findings to help understand the conscious and unconscious communications occurring in the data collection stage. Much of the psychoanalytic and psychodynamic literature refers to the work of psychotherapists. For this thesis, the term 'therapist' refers not purely to professionally trained therapists but to those working in a therapeutic setting using psychodynamic theory to support their work.

Psychodynamic theory has been used in residential childcare since the 1920s (Ward, Kasinski, Pooley, and Worthington, 2003), so it is not unique to the MBS. It pays attention to the 'psychic conflict' we all experience which can lead to unwanted behaviours. The use of psychodynamic theory draws from Freud's early psychoanalytical ideas, recognising that all individuals have an unconscious and that humans unconsciously repeat their early-life traumas as a method of self-preservation. It is through the examination of these communications that themes begin to emerge, which can be addressed within the residential setting (Ward, 2006).

The task of those working psychodynamically is to try and change the person from within, to see the behaviours of an inner conflict and thus to try and address the causes of the symptoms, rather than address the behaviours. "Symptoms (...) could be viewed afresh as meaningful communications about inner states of conflict" (Bateman, Brown and Pedder, 2000, p.9).

The history of psychoanalytic work dates to the late nineteenth and early twentieth centuries, with the work of Freud. Freud's work and significance are too broad for this study; however, the most significant idea stemming from his later work was the concept that all humans have an unconscious, based on our interactions and experiences, which influences our behaviour and relationships, though not at an unconscious level. Freud's psychoanalytic ideas have been developed into what is now termed 'psychodynamic theory', which includes a wider range of theories. These include the work of Adler (1927), Erikson (1950), Jung (1964) and Bowlby (1969) among others. Psychodynamic theory, which underpins this thesis, is perceived as a broadening of psychoanalysis, with the idea of 'unconscious' processes driving behaviour as a core concept. Freud introduced the now widely accepted idea of the 'iceberg', where two-thirds of our mind is hidden beneath the surface, influencing our behaviour, interactions and relationships.

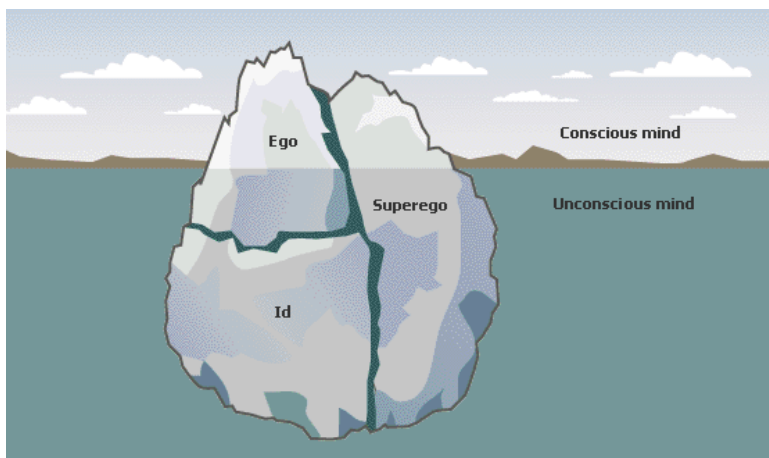


Figure 1: Freud's iceberg

Although highly influential, his ideas are not without limitations. Freud's early studies focussed on external realities, before making a pivotal shift towards unconscious processes, intrapsychic conflict and desire being the origin of distress (Onions, 2017a). Much of his work failed to take account of the influence of parents on their children's emotional development (Novick and Novick, 2000), whereas it is now widely accepted that parenting impacts upon the social and emotional development of children (James, 2011).

Psychodynamic theories expand upon Freud's psychoanalytic ideas, particularly the recognition of the unconscious, but are based on a more developmental perspective. Childhood relationships with caregivers are thought to play a central role in shaping later relationships. Although Freud originally understood the child's relational needs to be secondary to the mother's capacity to gratify drives, subsequent theorists have elaborated on the role of attachment needs as an equally significant force in development. One of the most prominent psychoanalysts to contribute to this understanding of early relationships was John Bowlby, who developed the idea of attachment theory, discussed in section 2.5.1. Other diverse components have also influenced the psychodynamic framework, including Freud's ideas of drive and ego-psychology, also developed by Anna Freud and Erik Erickson; object relations theory, as developed by Melanie Klein and Donald Winnicott; and the group relations ideas of Wilfred Bion. What links these different authors is the fundamental emphasis they all place on the basic human need for relationships.

One of the complexities of reviewing psychodynamic theory is the enormous diversity of the many components. Despite this, three central principles appear to each of the theorists. Firstly, human personality starts to form in the context of the earliest relationships (McWilliams, 2009). Secondly, there is a common understanding that these relationships become internalised as representations of the self, and thirdly, thoughts and feelings are often achieved in the context of these relationships (Bornstein, 2019).

2.4.1 Defences

A core principle of psychodynamic theory is the concept of unconscious defences, namely the unintended actions humans perform as a means to protect themselves from painful and stressful experiences, such as anxiety (Bateman *et al.*, 2000). The concept was initially put forward by Freud more than a century ago; he argued that defensive reactions occur when

the ego (a person's sense of reason and common sense, modified by the direct influence of the external world) attempts to protect itself from the id (the more unorganised aspects of the self, e.g. more primitive and instinctual desires and passions). Put another way, the ego is a descendant of conscious events, while the id is a descendant of the unconscious (Rycroft, 1995). For the children at the MBS, their 'id' often drives aggressive and unprocessed reactions as a response to their 'ego' reality. In modern times, the term 'defence mechanism' is used more broadly to refer to a range of psychological barriers used by people, unconsciously, to keep conflicts such as guilt or anger masked from conscious awareness (Greenhalgh, 1994). In the context of this study, these defences are adopted by children, families and staff as a means to avoid the emotional pain of a child's early-life trauma.

These defences can be grouped into (1) 'getting rid of', (2) 'reversal or transformation' and (3) 'flight and avoidance' (Dermen and Parsons, 1999). 'Getting rid of' can include transference, projection or denial; 'reversal or transformation' can consist of displacement or splitting; 'flight and avoidance' can include regression, using the body (e.g. to be aggressive) or intellectualisation. I will provide a brief overview of those defences most closely connected to my data analysis in chapter six.

2.4.1.1 Transference

Freud first described the concept of transference in his 1895 book *Studies on Hysteria*, where he noted the deep, intense and often unconscious feelings that sometimes arose within his therapeutic relationships. From this, Freud identified the concept of transference: the unconscious process of transferring emotion from a past relationship, often parental, onto another individual. This may relate to actual or imagined events. Casement (1990, p.7) spoke of transference as an 'expression of "unconscious hope" by which the [person] signals to the external world that there is a conflict needing attention'.

In a therapeutic setting, such as the MBS the therapist may be able to develop their understanding of the individual through recognising the transference they experience. As such, it is possible to create a deeper understanding of an individual's condition or aspects of their early life which affect them.

2.4.1.2 Counter-transference

An extension of this concept is counter-transference, described by Mattison (1975, p.36) as the 'therapist's response to the transference'. Freud recognised that the therapist could be prone to transference, but it was authors in the 1950s, such as Heimann (1950) and Gitelson (1952), who developed this as an example of clinical evidence (Holmes, 2014). Initially perceived by Freud as an impediment to the treatment process, counter-transference is now recognised as an essential tool for the therapist to identify whose feeling belongs to whom and to help the patient make sense of them. Psychodynamic theory, particularly Winnicottian early childhood disturbance, is widely used to consider counter-transference as communication, or enactment, which can help the therapist to make sense of the client's unconscious struggles, helping to identify appropriate therapeutic interventions (Lee, 2017). Both transference and counter-transference can happen in everyday interactions and are not exclusive to a therapeutic relationship.

2.4.1.3 Projection

As with transference, Freud believed projection to be a defence mechanism often used to avoid uncomfortable, repressed feelings such as jealousy, anger or sexual desire. These feelings are not acknowledged as one's own, but instead are imagined to be located elsewhere (i.e. they are ascribed to another) (Reber, 1995).

In modern psychology, it is recognised that these feelings do not necessarily have to be repressed to constitute projection; they can simply be feelings a person does not wish to

manage. Projection can be said to provide a level of protection against these feelings. As with other defences, projection is not exclusive to the therapeutic relationship, but is a regular feature of the working within the MBS.

2.4.1.4 Splitting

The last defence to be considered is that of splitting, which has been defined in quite diverse ways. The main definitions are of splitting within the ego, splitting of representations of the self, as well as internal and external objects (Savvopoulos *et al.*, 2011). This defensive process involves the splitting of the self, or objects, into good and bad components (Rycroft, 1995). This is often a response to conflicts, potentially leaving the individual with feelings which can feel dangerous and, in extreme cases, lead to mental illness (Bateman *et al.*, 2000). Winnicott (1958) also discussed this point, linking early relationship failure to later-life illness such as schizophrenia. More simply, splitting can be seen as the separation of painful feelings about trauma from the event; or being unable to consciously feel good and bad feelings towards the same person (Dermen and Parsons, 1999). This can occur within all relationships and interactions, and within the MBS would occur between individuals and groups (for example, teams).

These psychodynamic defences and concepts are all underpinned by the acknowledgement that unconscious processes influence communication between all the people involved in the care of children (Onions, 2017a).

2.4.2 Theorists

This section gives a brief overview of three theorists whose ideas and research are most relevant to this study.

2.4.2.1 Winnicott

Donald Winnicott's ideas have permeated our understanding of child development and child psychotherapy. Working closely with others, including Barbara Dockar-Drysdale, his ideas have been so influential and broad that they warrant a literature review to themselves (Philips, 2007). However, for this thesis, I will discuss the most pertinent ideas.

2.4.2.1.1 Good enough mother/parent

The 'good enough mother' is one who almost completely adapts to the needs of her baby. She is entirely devoted to the baby and quickly sees to their every basic need, physical and emotional – for example, sacrificing sleep to meet the infant's needs. However, as the baby develops, the mother allows the child to experience small amounts of frustration. She is empathetic and caring but does not immediately rush to the baby's every cry. As such, she is not 'perfect', but she is 'good enough': the child only feels a slight amount of frustration, yet still has their needs met.

Winnicott felt strongly about the mother's knowledge of her baby's needs, arguing that the mother had greater insight into these needs than any experts. There are:

very subtle things that the mother knows intuitively and without any intellectual appreciation of what is happening, and which she can only arrive at by being left alone and given full responsibility (Winnicott, 1988, p.64)

These ideas are particularly pertinent to this study's overall focus on understanding the impact of the early-life relationships between children and their carers.

2.4.2.1.2 False self

Winnicott (1963b) also developed the concept of 'environmental failure', which can occur at various stages of the child's emotional development. When the infant is in a phase of 'absolute dependence' upon their mother, such emotional failure could have significant later-life effects. He identified that an infant is most likely not to experience a 'good enough mother' when the mother, either consciously or unconsciously, is unable to respond to her baby's needs and behaviour, which he termed the 'true self', but instead imposes her wishes and desires on the baby. This, he felt, could lead the infant into 'compliance' behaviours ('false self'), which may lead to loss of personal autonomy and integrity in later life (Winnicott, 1963a). The idea of the 'false self' is relevant to many of the children within the MBS, whose struggle with their sense of self is compounded by living away from their families (Neagu and Sebba, 2019).

2.4.2.1.3 The capacity for concern

Many of Winnicott's ideas helped shape modern-day child development theories. One such development was the idea that young children, between five months and two years of age, develop a sense of personal responsibility for their actions. In healthy child development, this is the start of the child developing 'a capacity for concern' (Winnicott, 1963b). Winnicott linked this to the baby's growing capacity to experience guilt, representative of them becoming aware of a 'me' as separate from 'not me'. An extension of this is recognising that the mother is an independent person, with her own needs and feelings.

The baby becomes aware of expressing 'love complicated by hate' towards the mother. As this awareness becomes enriched and refined, it 'leads to the emergence of concern'. The baby's new capacity to experience primitive 'guilt' or 'shame' is linked with 'the damage which is felt to be done to the loved person in states of excitement' (Holmes *et al.*, 2018;

Tignor and Colvin, 2017; Winnicott, 1949). With the mother's love and care over time, the healthy infant can discover a 'personal urge to give, to construct and to mend'.

The achievement of concern requires two aspects of the mother coming together in the baby's mind: firstly, the mother's capacity to accept and tolerate the baby's natural loving and aggressive impulses; secondly, the mother's capacity for general loving care and everyday management of the baby (Winnicott, 1963b). Although Winnicott regarded the 'capacity for concern' as vital, even suggesting that the 'stage of concern' should replace Klein's concept of 'depressive position', it is no longer a widely used term. For example, 'capacity for concern' no longer appears in the *Dictionary of Psychoanalysis* (Tolmacz, 2008).

2.4.2.1.4 Holding

Winnicott's concept of holding has had a profound influence on the development of psychoanalysis since he first described it in 1953, and it is used widely across the MBS. He used 'holding' or 'holding environment' to refer to the experience of the child having their basic emotional responses, such as anxiety, contained and understood by their carer. This leads to the child's ability to trust adults and to recognise their feelings and thoughts, and to develop an ability to understand them, as well as to symbolise them and to play (Baumeister, 1987; Ward and McMahon, 1998). However, it is crucial to recognise that Winnicott was not just referring to the carers (often the parents), but to the quality of the relationships (Ward and McMahon, 1998). This focus on the relationship informs this study's research questions.

Although Winnicott has been influential, several criticisms of his work need to be considered. For instance, his emphasis on the mother can exclude the father (Payne, 2005). This can be likened to the work of Bowlby and may reflect the societal positions mothers and fathers held in the mid-twentieth century (Sharpe, 2006); nevertheless, a parental-cultural shift has emerged in the UK, with fathers having a more prominent role. Winnicott's ideas also faced

criticism regarding his own early-life experiences. For example, Minsky (1996) highlighted that Winnicott's personal experience of having to care for his depressed mother is likely to have influenced his ideas, particularly those about the 'false self, by reducing his impartiality, though this could be considered as developing his level of empathy'. However, despite these criticisms, Winnicott arguably remains one of the few twentieth-century analysts whose breadth of ideas and influence have allowed legitimate comparison to Freud (Casement, 1995).

2.4.2.2 Bion

Wilfred Bion was an important part of the post-war development of psychoanalytic thinking. Often working closely with Klein, he developed ideas about the function of groups as a therapeutic model. Much of his work was based on working with adults, mainly soldiers, who had had traumatic experiences, now recognised as post-traumatic stress disorder (PTSD). Much of his work was brought together in his 1960 volume *Experiences in Groups* (Bion, 1961), which remains an essential text. Bion (1962) also developed the ideas of psychodynamic theory in terms of the primary caregiver and the young child. He reinforced the view that the quality of relationships from early infancy onwards would be crucial to shaping the child's personality and character. Where the care is inadequate, the child's emotional development and ability to engage in relationships are impacted (Research and Harrison, 2015), linking directly to the ideas of Bowlby, Winnicott and Klein, among others.

2.4.2.2.1 Basic assumptions

Bion (1961) recognised the unconscious defences people use when working in groups, which gave rise to his idea of 'basic assumption', which argues that in every group two groups exist: the work group and the basic assumption group. The work group is based upon the group's primary task or purpose, while the basic assumption group is based on the unconscious processes or underlying assumptions on which the group's behaviour is

based. Within this, Bion (1989) identified three basic assumptions: dependency, fight-flight and pairing. When a group adopts any one of these basic assumptions, it interferes, at an unconscious level, with the task the group is attempting to accomplish. In this study, these ideas help us to understand how the children manage in groups – a key part of the therapeutic process – and how families and staff function and impact the children. Understanding what is happening in the groups is a basic task for staff across the MBS.

During dependency, the essential aim of the group is to have one individual protect its members. The group assumes that there is an external object whose function is to provide security for the immature individual. The group members behave passively and act as though the leader is omnipotent. For example, the leader may pose a question, only to be greeted by silence. The leader may be idealised into a kind of god who can take care of their children, and some especially ambitious leaders may be susceptible to this role. Resentment at being dependent may eventually lead the group members to ‘take down’ the leader, and then search for a new leader to repeat the process.

In fight-flight, the group behaves as though it must preserve itself at all costs, either by running away or fighting someone or something (Bion, 1961). In fight, the group may express aggressiveness and hostility; in flight, the group may chit-chat, tell stories, arrive late or do anything else that avoids addressing the task at hand. The leader of this sort of group is one who can mobilise the group for attack or lead the flight.

Pairing exists on the assumption that the group has met for reproduction: that two people can meet for only one sexual purpose (Bion, 1961). Two people carry out the work of the group through their continued interaction. The remaining members listen attentively with a sense of relief and hopeful anticipation.

In addition to Bion's three basic assumptions, Turquet (1975) provides a fourth basic assumption that accounts for difficulty in group participation: 'oneness'. This refers to 'members who seek to join in a powerful union with an omnipotent force, unobtainably high, to surrender themselves for passive participation and thereby to feel existence, well-being and "wholeness"' (p.357). Whereas Bion's ideas focussed purely on the functioning within a group setting, Turquet (1975) considered wider impacts upon group functioning. This was developed into the idea of 'me-ness' by Lawrence *et al.* (1996), whereby the group membership is impacted by societal change, leading to a culture of selfishness.¹¹ This societal shift away from group identities may help to explain why the MBS's historical large group model appears to be shifting towards a smaller group model. This is supported by Diamond's idea of the move from intense relationships, with a small number of staff, to a more shared model with a much larger staff team (2004).

2.4.2.2.2 Container/contained

Bion's (1963) concept of the 'container/contained' is used widely within the MBS and can be linked to Winnicott's concept of the 'holding environment' (Hannon *et al.*, 2010; Ward and McMahon, 1998), though its origins are perhaps more closely linked to Klein's original description of 'projective identification' (Hinshelwood, 1989). Bion's theory (1959) explains how the mother (carer) takes unwanted projections from the infant (child), processes them and returns them in a more manageable form. Bion recognised that this process was mirrored in the therapist's interactions with the client, whereby the therapist acted as a 'container' for the client's overwhelming thoughts and feelings. This concept is directly related to the work between staff and children throughout this thesis. Bion (1959) extended these ideas to describe social groups as a form of 'maternal container' (Finlay, 2015).

¹¹ It must be noted that this work was not explicitly related to residential childcare.

Although I have represented the links between Winnicott's and Bion's concepts, there is a body of psychoanalytic literature, such as Parry (2010), that challenges this, presenting different psychoanalytic viewpoints of the two concepts, but also questioning whether this impacts on patient/analyst relationships. Given that this thesis uses psychodynamic theory, rather than the more deeply theoretical psychoanalytical concepts, these potential differences are not considered to impact this study significantly.

2.4.2.3 Klein

Like Winnicott, much of Melanie Klein's work was developed through working with other psychoanalysts during the 1930s–1960s. An Austrian/British psychoanalyst, her work is often attributed to our current understanding of concepts such as splitting, projective identification, unconscious phantasy and the use of counter-transference. She is regarded as one of the founders of 'object relations theory' (Klein, 2011), developed from Freud's psychodynamic ideas. Klein's work is extensive, but I review only those parts which I draw on in this thesis.

2.4.2.3.1 Object relations

Klein's ideas of object relations can be seen as a collection of smaller theories which explore the internalised relations between primary carers during infancy, which Klein regarded as 'objects', and the unconscious influence these have on developing a child's relationships (Klein, 2011). Again, the emphasis is on the unconscious process, and several of the criticisms already highlighted can also be applied to Klein's work. Klein's theories suggested that children internalise not only the object (the primary carer) but the entire relationship. This is done as the infant internalises two sets of objects, relations with both positive and negative aspects. These encompass representations of the child's self, the object and the emotional links between the two.

These theories have been developed by others, notably Fairbairn (1952). Although Fairbairn's ideas are not as widely acknowledged as Klein's, it has been argued that his development of Freud and Klein's ideas has been more influential on modern-day object relations theory (Chessick, 1996).

The psychodynamic approach stresses the importance of understanding the emotional development of children, helping to address the cause of the symptoms, rather than purely respond to the behaviour. This idea of 'behaviour as a communication of a child's unmet needs' is not new but is at odds with the more traditional behaviourist approaches often used across the UK in childcare settings. Psychodynamically, children's negative behaviour is not always seen as something which must be stopped or 'punished', as it is how the child expresses how they are feeling.

While many support the use of psychodynamic theory in therapeutic childcare (Clough *et al.*, 2006; Rose, 1990), some authors are critical of the approach. The primary criticism suggests that psychodynamic theory ignores mediational processes (e.g. thinking) due to the over-focus on unconscious processes (McLeod, 2017), making the model unscientific. It can be argued that psychodynamic theory, with its origins in the work of Freud, relies too heavily on Freud's case studies – for example, Little Hans and Anna – and thus cannot be generalised to broader populations.¹²

These criticisms of both psychoanalytic and psychodynamic thinking can be argued in depth, but I do not have space here to discuss them further. McLeod (2017) further argued that the psychodynamic approach fails to give sufficient consideration to the biological and genetic factors which can contribute to mental health issues, and that the model is

¹² Given that my study is based upon the use of case studies, this criticism is addressed in further detail in chapter three, with emphasis given to Flyvbjerg's (2006) paper, which challenges a number of misunderstandings about the case study approach.

unscientific as unconscious processes cannot be tested. Further criticisms suggest that the theory lacks empirical research to support it and is too deterministic, denying that people can exercise free will (Deal, 2007). Another argument is that interventions labelled 'psychodynamic' are often poorly defined (Fonagy *et al.*, 2005).

Concerning the MBS, this criticism appears somewhat ameliorated by the consideration given to neuroscience,¹³ discussed in section 2.5.3, and to staff training in areas such as child development (Diamond, 2013). One of the strengths of psychodynamic theory is that it has evolved to encompass new components (Deal, 2007), including object relations, discussed in section 2.4.2.4.

Some of these criticisms appear to be linked to professional backgrounds, so are arguably biased towards different models. While it is essential to recognise these criticisms, there is a wealth of supporting evidence for the use of psychodynamic theory for some client groups (Courtois, 2004; Emanuel, 2002; Sharpe, 2006).

In considering these criticisms, it is worth recognising the changing political and social landscapes which have impacted residential and therapeutic childcare. In the 1980s, therapeutic approaches, often underpinned by psychodynamic theory, were criticised for isolating young people from their communities and families (Millham *et al.*, 1986). This criticism signalled a political and social move away from residential childcare.

Subsequently, fewer children were placed in residential care – the number reduced from 7,600 to 4,878 over a decade (Lenehan and Geraghty, 2017) – and instead many were placed with foster carers, with the location of their communities and families often given precedence over which placement could best meet their needs.

¹³ The neuroscientific research focusses on early relationships and parenting and the impact of trauma on the brain.

Further shifts were seen in the 1990s, which drew focus away from psychodynamic approaches. This period saw a shift in government and local authorities, which began to demand instant and finite solutions to issues such as school exclusion rates and children's behaviour (DfE, 2017; Sharpe, 2006). Care moved from being relationship-based, towards models that were quicker and, in the shorter term, cheaper. This links directly with the criticism of psychodynamic theory having limited evidence to support its effective use. The development of standards and assessment make it hard for psychodynamic settings to retain their focus on the 'whole person' approach (Sharpe, 2006). As such, shorter-term models, such as cognitive-behavioural interventions, have been relied upon due to the ease of descriptive outcome measures, despite reservations (Taylor, 2004).

2.5 Emotional trauma

A traumatic experience impacts the entire person – the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel about other people and the way we make sense of the world. (Bloom, 1999, p.2)

Having discussed the theorists whose work informs this study, I now turn more directly to the work of the MBS, focussing on theory relating to emotional trauma; this is something all the children have experienced, which has led to them being placed at the school.

2.5.1 Attachment

Attachment can be defined as the enduring bond of affection directed towards a specific individual (Santrock, 2001). Attachment theory is now so influential that the term 'attachment-informed practice' is routinely used through different disciplines of social work, education and psychology (Furnivall, 2011). The theoretical ideas of attachment stem from the seminal work of John Bowlby (1958), a child psychiatrist throughout the 1930s, who worked with children who had experienced emotional trauma. His work led him to describe

babies as being 'innately predisposed' to become attached to their caregivers (Bowlby, 1969). Bowlby took an interest in the relationships children develop with their mothers, and the impact on their social, emotional and cognitive development. He developed these ideas in post-war Britain, when many evacuee children were separated from their mothers, specifically linking early infant separation from the mother with later-life maladjustment, a concept he referred to as 'maternal deprivation'. Bowlby hypothesised that if the attachment figure is broken or disrupted within the first two years of life, the child will suffer irreversible long-term consequences. He described how prolonged separation of a child from their primary carer could cause distress and have detrimental outcomes for the child. The child needs the 'secure base' of a solid attachment relationship from which to safely explore the world:

All of us, from the cradle to the grave, are happiest when life is organised as a series of excursions, long or short, from the secure base provided by our attachment figures. (Bowlby, 1988, p.62)

Bowlby worked closely with other clinicians, such as James and Joyce Robertson (1971), who filmed a number of children in hospital settings to show that, when separated from their mothers, children experience high levels of distress; they exhibit a sequence of behaviours in which distress is initially accompanied by protest, despair and eventually denial and emotional detachment from the primary caregiver (Robertson and Robertson, 1971).

Bowlby's theories challenged the more behaviourist theories, such as Dollard and Miller (1950), which suggested that attachments are a set of learned behaviours; Bowlby felt this underestimated the child's bond with their mother. Bowlby proposed that children's early experiences and their relationship with their primary carer are fundamental in their psychological development and needed to be viewed within an evolutionary context. These ideas were developed to explain how the parent--child relationship emerges, influencing subsequent development, which Bowlby defined as the 'child's internal working model'.

Bowlby described how infants have a basic need to seek proximity with their caregiver, particularly when under stress or feeling threatened (Prior and Glaser, 2006). Bowlby, Harlow and others helped develop the 'evolutionary theory of attachment', proposing that children are born biologically predisposed to form attachments with others as a means to survive (Bowlby, 1969). In a healthy relationship, the infant responds to stress through their behaviour, such as smiling or crying, which stimulates an innate caregiving response from the carer. Bowlby (1969) suggested that the baby's determinant of attachment is not food, but warmth, affection and attention.

Attachment theory suggests there is a critical period for developing attachment (Bowlby says the first two years, while other authors say the first 1,000 days). The attachment forms the foundations upon which the child will build all future relationships; interrupting it can cause long-lasting negative ramifications, including developmental issues affecting intelligence and increasing aggressive behaviours. Bowlby can be seen as the founding father of attachment theory, and his work was continued by other leading clinicians, including Harlow and Zimmerman (1958), Schaffer and Emerson (1964), Ainsworth *et al.* (1978) and Main and Solomon (1990). Subsequent writings about attachment are still heavily influenced by the work of Bowlby, though the focus has moved from the mother to any primary carer, to account for societal changes whereby an increasing number of infants are cared for by people other than the mother.

One of the most significant theorists since Bowlby has been Mary Ainsworth, who developed a triarchic taxonomy of primary attachment types – 'secure', 'avoidant' and 'resistant' (Ainsworth, 2014) – as a way of classifying infant behaviour. The secure type is an infant who seeks protection or comfort and receives it consistently. The avoidant type tends to pull away or ignore their carer, which Ainsworth felt resulted from the carer usually rejecting the

infant's attachment behaviour. The resistant type tends to stay close to the carer but receives inconsistent care.

Ainsworth's development of attachment types was based on what became known as the 'strange situation', an experimental procedure to observe the variety of attachment types exhibited between mothers and infants. The experiments were set up in a small room with one-way glass so the behaviour of the infant, aged between 12 and 18 months, could be observed. Each infant was observed for eight 3-minute episodes, and from these Ainsworth identified the different types of attachment.

Although there is some criticism that Ainsworth *et al.*'s model (1978) was based on an artificial clinical environment, and at a fixed point in time (Waters and Beauchaine, 2003), these classifications still underpin current thinking about attachment. Latterly, Main and Solomon (1990) have added 'disorganised/reactive' as an additional classification of attachment, to recognise the behaviours of infants who have experienced both love and fear from parental figures – often through abuse. These later classifications, which are seen as likely predictors of later-life mental health issues, including borderline personality disorders (Bateman and Fonagy, 2004), are referred to throughout this study. A child with a secure attachment is significantly more able to develop trusting relationships and regulate their own emotions and behaviour (Furnivall *et al.*, 2012).

In more recent times, Pat Crittenden, an American developmental psychopathologist, who studied under both Ainsworth and Bowlby, has developed the Dynamic-Maturational Model of Attachment and Adaptation (DMM), in which she highlights the need to focus on past experiences and defences, and the strategies people use to cope. The DMM represents a shift away from the more traditional theories of attachment, which has naturally led to some academic challenges in the field (Holmes and Farnfield, 2014). These appear principally to

focus on Main and Solomon's (1990) introduction of the disorganised attachment type, while Crittenden's DMM was geared towards sub-dividing Ainsworth and Bowlby's existing types.

Attachment has been extensively written about for over 60 years, and it is widely accepted as the most critical influence on psychosocial development (Bowlby and Winton, 1998), yet it is not without challenges. Some academic psychologists and parts of the psychoanalytic community have criticised Bowlby's renunciation of popular 'drive' theories in favour of an arguably reductionist emphasis on evolutionary factors (Fonagy, 2001). One of the most significant limitations is that the model of attachment is based on behaviours which occur during momentarily stressful situations, such as separation from the primary carer, and thus potentially fail to give enough credit to the relationship during non-stressful periods (Field, 1996). Bowlby has also been criticised for identifying attachment behaviours with the primary carer, often the mother, and thus failing to give sufficient attention to children's multiple attachments, or to recognise that children's attachment behaviour can differ between attachment relationships. Furthermore, Rutter (2005) highlighted that there remains no definitive understanding of the processes linking early-life experiences with individual characteristics. Rutter (1981) undertook research into the relationship between infants and carers and the impact of this on later life. However, unlike Bowlby, he concluded that the conflict and stress which come before separation, rather than the separation itself, cause antisocial behaviour. This represents a significant difference in viewpoint, but subsequent authors, including Rutter (2005), have linked the two more closely, suggesting that it is often conflict and stress which lead to separation, and hence they cannot be seen as mutually exclusive (Rutter, 2005). Rutter, like Bowlby, undertook large-scale research and interviews with children, though notably only with boys from one part of the UK. Also, like Bowlby's work, Rutter's study was retrospective: he undertook many interviews with adults, who were asked to recall events and emotions from up to 12 years prior, creating a potential weakness due to memory recall.

Educationalists have been critical of emphasising early-life experiences as predictive of adverse later-life outcomes. Bowlby's (1951) ideas of maternal deprivation were challenged by societal changes, such as a growing recognition that some separation – for example, high-quality daycare – may not necessarily have long-term effects on a child's attachments and future relationships. This can be linked to Rutter's ideas that the impact is felt within the relationship before the separation.

However, many of these criticisms are rebuffed by authors such as Slater (2007), who argue that many over-emphasise Bowlby's early work and studies, thus misunderstanding all the issues of attachment. Bowlby himself (1988) appears to reject some of the earlier emphasis of his work on deterministic models of child development. Slater (2007) suggests that, while attachment theory does not provide a model for understanding all human behaviour, it is a vital tool for understanding some of the more confusing and challenging behaviours presented by some of the most vulnerable children.

Despite these challenges and developments in thinking, the idea that a child's attachment type is dependent on their early experiences with their primary carer (though not necessarily their parent) remains core to child development theories. The impact of children's behaviours, as well as how their ability to make and maintain relationships manifests differently depending on attachment type, are still recognised. Several authors (Ainsworth, 1989; Bowlby, 1988; Hughes, 2006) have documented research showing strong links between early-life trauma and the inability to develop a secure attachment. This indicates that traumatic experiences have a profound impact on children's functioning (van der Kolk, 2005, 2014), including an inability to develop a secure attachment and relationships, often leading to impulsive and self-destructive behaviours.

2.5.2 Trauma

My study focusses on children within the MBS who have predominantly ambivalent or disorganised attachments, often manifesting through violent and aggressive behaviours and leading them to experience difficulties with relationships. A strong correlation exists between attachment and trauma, with trauma increasing through the lack of attachment (Lubit *et al.*, 2003) and often impairing children's relationships with peers and families, particularly through having insecure or disorganised attachments (van der Kolk, 2009). Winnicott (1986) described trauma as breaking the continuity of an individual's existence. When a child experiences trauma or abuse, they learn that they cannot trust or rely upon others (NCTSN, 2018). Without trust, they lose the ability to develop healthy relationships and form attachments (Osofsky and Fenichel, 1994), thus reducing their ability to self-regulate (Schoore 2001). The child is left in a cycle of trauma and attachment.

The impact of trauma on children is complex. Research suggests that there has been a rise not only in the number of children affected by traumatic experiences, which in the USA is anticipated to be as high as 50% of primary-aged children (NCTSN, n.d.),¹⁴ but also in the severity of the trauma (Cafcass, 2012; Donnelly, 2013). Different types of trauma have been identified, with de Thierry (2015) developing a 'trauma continuum' – see figure 2. This builds on Terr's work (1991), which identified Type I trauma (traumatic exposure, brief in duration, e.g. an accident) and Type II trauma (prolonged or repeated exposure, e.g. abuse). Heide and Solomon later defined Type III trauma: multiple, pervasive or violent events at an early age and continuing over some time (Heide and Solomon, 1999).

¹⁴ This 50% figure relates to children who have experienced trauma; the 30% figure highlighted in chapter one relates to children who have experienced childhood maltreatment.

The Trauma Continuum

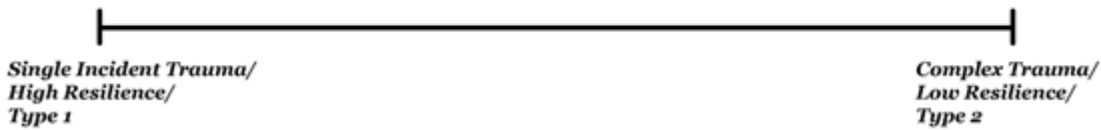


Figure 2 : Trauma continuum

2.5.3 *Complex trauma*

The phrase 'complex trauma' is used throughout this study to describe the experience of multiple, chronic and prolonged developmental adverse traumatic events (Cook *et al.*, 2005; Courtois, 2004; Luxenberg *et al.*, 2001). Complex trauma is seen as involving physical and sexual abuse, with an increase in neglect now being recognised as a cause (Perry, 2006a). Complex trauma describes the dual problem of children's exposure to traumatic events and the impact on short- and long-term outcomes. The children referred to the MBS have all experienced complex trauma, with the majority having experienced pre-verbal neglect and abuse (Onions, 2013).

Complex trauma affects children in a multitude of ways, including their attachment and relationships, behaviour, physical health (body and brain), dissociation and learning, and emotional responses (NCTSN, 2018). De Thierry (2015) and Cattanach (1992) also highlight the strong relationships between trauma and children's behaviour, and the ability to self-regulate and learn.

The impact of complex trauma can also be physiological; the brain's development can be physically altered (Solomon and Siegal, 2003). There is now a wide range of research linking neuroscience to attachment theory (Schore, 2001; Howe, 2005; Music, 2011) and identifying how the neural pathways in the brains of abused children are physically impaired. Those with complex trauma often come from violent or emotionally volatile environments where

parental stress may lead to increased cortisol levels for the baby, leading to the baby's brain becoming wired to keep them in a self-protective mode for survival and defence.

Trauma impacts how children perceive themselves and the world around them, in turn affecting how they respond to other people and their environment (Cozolino, 2006). There is significant evidence for the impact of trauma on children's and adults' mental health (BPS, 2011; Read *et al.*, 2005; Stover and Berkowitz, 2005). Many young children internalise their trauma, leading to regression, dissociation or withdrawal (Perry, 2006b; Stover and Berkowitz, 2005). However, much of the literature relates to children who externalise their trauma or struggle with self-regulation (Schore, 2001). These children are often unable to 'calm' themselves and may lack impulse control, returning to 'fight-or-flight' defence mechanisms which often manifest in behavioural difficulties such as aggression, violence and sexualised behaviour. However, much of the research is based on small studies and there is conflicting evidence about the connection between childhood trauma and adult psychosis and mental health (Morgan and Fisher, 2007).

The concept of self-regulation in relation to childhood trauma is extensive in the literature (Lubit *et al.*, 2003; Perry, 2009; de Thierry, 2015). Self-regulation is a core process of healthy development, whereby humans recognise their own stress responses, learn to read their body's signals and act accordingly to regulate their level of stress. The literature repeatedly highlights that children who have experienced trauma are unable to self-regulate (Lubit *et al.*, 2003), are often unaware of their bodily states and, as a result, are unable to respond to them. Developments in theoretical understanding over the last 20 years have mainly followed a neuroscientific perspective (Perry, 2007), repeatedly evidencing that the chemical imbalance in a child's brain is a direct result of their early-life trauma. These ideas are being used more frequently when working with traumatised children, particularly in the USA, but increasingly in the UK and Europe. The literature relating to the traumatised brain is in its infancy, but a significant body of literature (much of it neuroscientific) from the last 20

years recognises that trauma directly relates to concepts such as attachment (Cozolino, 2006; Perry, 2009). The main criticism of the neuroscientific model relates not to the theory, but to ethical ideas about how insights into a child's brain can be gathered and how this information can be used to develop practice.

While considering trauma, it is necessary to consider the concept of 'vicarious trauma' (VT). Pearlman and Saakvitne (1995) highlight the complexity of talking about trauma and abuse with children, and identify a number of common factors which contribute to therapists experiencing VT, including: exposure to client's trauma, the chronicity of trauma work, the individual's capacity for emotional empathy and a history of personal trauma. The impact of working therapeutically alongside children and families who have experienced trauma is highly relevant to this study. However, other authors – for example, Devilly, Wright and Varker (2009) – challenge Pearlman and Saakvitne's work on VT, citing no consistent correlation between therapist VT and working with trauma.

2.5.4 Relationships

Authors have contemplated the importance of student–teacher relationships (Klem and Connell, 2004; Moore *et al.*, 2018). Perry (2002) considered how trauma, particularly involving abuse, can impact children's ability to build relationships, causing challenges for staff. Dods (2013) highlighted how students who lack trust in adults are more likely to test and resist efforts to form relationships, a psychological defence to avoid further pain and rejection. Lack of self-worth can leave children feeling undeserving of care, leading many to reject and seek control through their behaviour. This is the experience of many of the children at the MBS (Onions, 2013).

Healthy school-based relationships are an essential predictor of decreased risk-taking behaviour in children and young people who have experienced trauma (McNeeley, 2005).

However, it is often unclear what is meant by 'forming healthy relationships'; UK government policy makes a number of references to the term without defining it. One exception is the work of Bloom (1999), who identified four aspects of relationships which are most supportive to those who have experienced trauma: (1) being teacher-driven, (2) being authentic and caring, (3) being attuned to children's emotional states and (4) being individualised (Bloom, 1999). However, this study is broader than school-based relationships, and considers healthy relationships to be those which support the emotional, physical and social development of the child.

Children and young people often value and appreciate healthy, caring relationships, despite appearing to reject them (Dods, 2013). Mihalas *et al.* (2009) attributed this to a background of chaotic and uncaring relationships, which makes it difficult for children to internalise caring actions or reciprocate healthily.

Much of the literature related to traumatised children's relationships (Bolger, Patterson and Kupersmidt, 1998; Reyome, 2010) is USA- and Canada-based, focussing on secondary-aged children, often in school settings. This review has found little besides anecdotal evidence relating to primary-aged children's need for relationships, particularly those who have experienced trauma, or are in a residential setting.

Where children have been unable to develop healthy relationships, thus impacting their behaviour and mental health such that they require interventions, the evidence suggests that the type of intervention delivered is too often based on the child's behaviour rather than the underlying need (Clough *et al.*, 2006; Smith, 2014). For example, what connects both the internalisation and externalisation of behaviour is the inability to create and maintain relationships, yet what often separates them is the interventions they receive. Those who externalise their behaviour are more likely to be excluded, to suffer placement breakdown

and to enter residential or therapeutic settings, while those who internalise – for example, those who self-harm or become withdrawn – are often left unidentified (Smith, 2014).

There is evidence that young children who have been exposed to violence, as many in therapeutic and residential care have been (Bullock and Blower, 2013), develop increased difficulties with behaviour and relationships. This directly impacts their ability to access learning, although there is also evidence that learning is affected due to distractibility, concentration problems and lack of self-regulation (Lubit *et al.*, 2003). Difficulties with learning are compounded by some of the major symptoms of trauma: struggling with relationships, avoidance of intimacy and emotional closeness (de Thierry, 2015) and lack of trust in others (James, 1989). The literature consistently highlights the inability to create and maintain relationships (Osofsky, 1995) – hence this study's focus on how the therapeutic approach affects children and their relationships.

While several authors discuss the need for appropriate interventions (Cattanach, 1992; de Thierry, 2015), it is essential to note that therapeutic residential provision as a superior intervention remains unidentified within the literature. What is clear is that the use of a trauma-focussed intervention, which uses attachment as a foundation for clinical interventions, is critical in the promotion of recovery in young children affected by complex trauma (Osofsky, 2004). Although the term 'attachment' is not consistently used, there appears to be a consensus that interventions should be relationship-based (Courtois and Ford, 2012). The use of relationships as a model for intervention is further highlighted by Gharabaghi (2008), among others, yet, ironically, the children who most need a relationship-based approach are those who struggle to develop and maintain relationships.

Trauma, attachment, relationships and behaviour are clearly connected. Perry (2006a) notes that to heal a damaged or altered brain, interventions must target portions of the brain affected by the trauma. Because repeated experiences alter brain functioning, interventions

should not be limited to regular therapy appointments, or by the 'appalling lack of effective therapeutic services for these children' (Perry, 2006a, p. 29). Instead, they should be holistic, addressing all aspects of the child's life and providing frequent, consistent replacement experiences. This, I would argue, supports the idea of residential therapeutic environments, rather than environments with therapy.

2.5.5 Violent, destructive and antisocial behaviour

Strong evidence suggests that children's trauma is related to violent, destructive and antisocial behaviours. This highlights the physical impact of trauma on the child's developing brain, and their unconscious repeating of past trauma, much of which is linked to violence. Glasser (1998) referred to this as 'self-preservation violence' (p.888), and the aforementioned 'fight, flight or freeze' defence response. Perry (2006a) highlighted 'hundreds of studies' (including Perry and Pollard, 1998; Bremner and Vermetten, 2001; Bremner, 2003; Anda *et al.*, 2006; Perry, 2009) that documented the negative impact of trauma, and these stretching across a range of fields including child protection, psychology and psychiatry. While many of the children in this study show violent and aggressive behaviours, I am not exclusively looking at violent children. As such, this review is not proposed to be comprehensive in this field, but it recognises the links between violence and trauma in children.

The most recent of these studies approaches the topic from a neuroscientific stance, providing insight into the negative impact of trauma on the developing brain. This includes abnormal brain developments in the cortical, limbic and midbrain structures (van der Kolk, 2009; Perry, 2006a), leading to difficulties in self-regulation and increased antisocial, aggressive behaviours.

Dockar-Drysdale's paper 'The Management of Violence' (1998) relates directly to the exhibition of violence within the MBS. She describes her experiences of violent emotions within the MBS and observes that the starting point for managing the children's violence is for the staff team to be aware of their aroused feelings from the violence. Thus, she provides a link between violence, psychodynamic thinking and the ability of the staff to reflect. While the ideas within this paper remain important, it must be acknowledged that the population of children at the MBS has changed significantly (Rollinson, 2018): the children are now more prone to impulsive reactions such as violence than those whom Dockar-Drysdale discussed. Graham-Bermann and Levendosky (2011) also identified the significant impact intimate partner violence (e.g. between parents) has on children. This supports Rollinson's (2018) view that the child group within the MBS is changing, as 68% of children in the school now have been impacted by intimate partner violence.

While there is evidence relating childhood violence and antisocial behaviour to a child's own experience of violence, including intimate partner violence, there is also evidence suggesting that children's exposure to community violence does not correlate with their own levels of violence (Cooley-Quille *et al.*, 1995). However, that study is based on community violence, rather than in-home or on-child violence, and as such does not apply to this study significantly.

2.5.5.1 Adverse Childhood Experiences (ACEs)

A more recent development in the understanding of trauma, including the impact of violence, comes from Felitti and Anda's (1998) work examining the links between ten identified Adverse Childhood Experiences (ACEs; see appendix 7), the links to subsequent mental and physical illness and the correlation to death rates. Building on this work, Corcoran and McNulty (2018) explored the direct relationship between children who have experienced ACEs and attachment difficulties, determining a strong correlation between children with

higher ACE scores and anxious and avoidant attachment styles. Grey literature from within the MBS shows that the number of children who have experienced four or more ACEs increased from 33% to 68% between 2005 and 2017 (Onions, 2017b), supporting Rollinson's (2018) view about the changing population of children placed at the school.

This study focusses on children within the MBS who have experienced trauma and abuse in their early lives. I have established that the majority of children at the school have experienced pre-verbal neglect and abuse (Onions, 2013), but before exploring the literature relating to the school, it is necessary to understand two of the school's core models of work, reflective practice and group work, and how these fit within a therapeutic residential childcare approach.

2.6 Therapeutic residential childcare (TRC)

Therapeutic childcare is often reserved for the most emotionally disturbed children within a range of residential schools and communities, outside of the mainstream education provision and for whom foster care is not appropriate (Bullock, 2009), and it is within this field that the consideration of ACE scores is particularly relevant. The children in TRC are often referred to as 'troubled and troublesome' (Bullock, 2009) or the 'most disturbed and difficult children and young people' (Ainsworth and Hansen, 2005). Their early-life experiences have typically led to them to become 'looked after children' (LAC), and many have experienced multiple placements before a specialised residential setting was considered (Macdonald and Millen, 2012; Stanley *et al.*, 2005; Ward, 2006). Stanley *et al.*'s (2005) findings further highlight the mental health needs of a large proportion of children in residential care, and the need for therapeutic input, or at least therapy, to address these difficulties. Figures suggest that 10%

of 5–16-year-olds in the UK are likely to have a diagnosable mental disorder¹⁵ (Department for Education, 2013; Green *et al.*, 2005; Meltzer *et al.*, 2003), and this figure rises to 45% for LAC (Meltzer *et al.*, 2003), an issue recognised as affecting children within the MBS (Onions, 2013).

Despite the importance of understanding the role and impact of TRC, it is a seemingly nascent area of research (Dooner and James, 2019), with most of the available research focussing on short-term outcomes. Following an increased emphasis on evidence-based practice in policy and, subsequently, academia, the academic field has seen an increase in research focussing on short-term residential care outcomes (Dooner and James, 2019; Martinovich *et al.*, 2007). However, it is unclear what is meant by therapeutic input. Whittaker, La Valle and Holmes (2015, p.25) provide a clear definition of therapeutic residential care, which they use to underpin their international collection of papers exploring evidence-based practice relating to this field:

Therapeutic Residential Care involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialisation, support and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources.

Although this definition is helpful, it is open to interpretation by different organisations and professionals. This lack of definition was identified by Gallagher

¹⁵ Meltzer *et al.* (2003) used the term 'mental disorders', as defined by the ICD-10 (International Classification of Diseases), to imply a clinically recognisable set of symptoms or behaviours associated, in most cases, with considerable distress and substantial interference with personal functions.

and Green (2013) and Knorth *et al.* (2003), who highlighted the limited amount of research relating to TRC, and how reviewing the literature proved complicated for two primary reasons:

1. The lack of definition of the term 'therapeutic'
2. Outcomes are poorly described, or not at all (Knorth *et al.*, 2008)

Further limitations of TRC-related research include the lack of evidence pertaining to long-term outcomes, and, where long-term evidence is available, the lack of standardised assessment models resulting in reduced applicability (Dooner and James, 2019).

2.6.1 Lack of an agreed definition

As well as the lack of standardised assessment models, the lack of a widely adhered to definition of 'therapeutic' makes it difficult to compare models of intervention, let alone outcomes. This means the capacity to benchmark different models is severely limited. Despite Whittaker *et al.*'s (2015) definition, it is the lack of a consistent definition which regularly stands out in the literature. Evidence suggests that, in the USA, the term covers a wide range of provision (Gallagher and Green, 2013), and in the UK there is similar, though less wide, diversity (Ward *et al.*, 2003), although there is a noticeable lack of information relating to these UK services (Bullock, 2009). This diversity of provision is recognised to include several variables, such as the theoretical underpinning model (Bettmann and Jaspersen, 2009), the duration of the placement, and the length and type of therapy (Curtis *et al.*, 2001). Accordingly, staff training is often based on behaviour modification and crisis intervention, with no evidence of a therapeutic underpinning to the work, highlighting the differing use of language and the lack of a definition.

In the UK, the language of 'therapeutic approach' is challenged by de Thierry (2015), who suggests that this is not enough for children with complex trauma. Moreover, a definition of

'therapeutic' requires both a neuroscientific and a psychoanalytic perspective (Ouss-Ryngaert and Golse, 2010), a view shared by Diamond (2013b) in his discussion of the development of the MBS. The use of neuroscience is relatively new in the field of trauma, particularly outside the USA, and there is a noteworthy gap in the literature to relate these different models together.

Only a few texts (Bloom, 2005; Carter, 2010; Cross, 2012) directly reference Haigh's (2013) five key elements, though none use them to clearly underpin a model of therapeutic work, making comparison with the MBS difficult. Bloom's (2005) description of the Sanctuary Model of Organisational Change™ uses different language, but can in some aspects be aligned to Haigh's (2013) key elements, and thus to the MBS model.

The work of Bloom (2005) and Carter (2010) details therapeutic work with children who have experienced exposure to violence, abuse and neglect, similar to those at the MBS, and have been placed in residential settings. Carter's (2010) study used video and interviews of adolescents based at Thornby Hall Therapeutic Community and found that the young people spoke positively about their developing ability to relate to others and form relationships, connecting to Haigh's framework and this study's research question. Bloom's (2005) US paper describes the basic theoretical model used by the Sanctuary Model™ of organisational change as a residential setting for adolescents. While Bloom's writing is not based on findings, it does helpfully outline the model's expected outcomes.¹⁶

However, both studies focus on an older population, and although they define their therapeutic models, there are some differences between these models and the MBS which need to be comparatively considered. For example, Carter's (2010) description of working

¹⁶ Summary of Bloom's (2005) expected outcomes of the Sanctuary Model™ for adolescents: less violence, systemic understanding of trauma and abuse, less victim blaming, clearer boundaries and expectations, earlier identification with perpetrator behaviour, ability to articulate goals and justify holistic approach, understanding of re-enactment behaviour, more democratic environment and better outcomes for the children, staff and organisation.

with groups has a similar theory base to the MBS. However, it is clear that an adolescent group has more capacity to use the group for reflective thinking, while primary-aged children, who are often more chaotic in their behaviours, may require a pre-verbal group experience – i.e. merely being in a group, perhaps for a meal or a game. Bloom's (2005) model appears very similar to the MBS, but there is insufficient background given to the types of children they work with, and, as Gallagher and Green (2013) highlighted, these often vary widely in the USA. However, these two studies are beneficial for recognising where the MBS fits in the field of therapeutic childcare.

There is also limited differentiation between different groups of children and types of residential setting (Little *et al.*, 2005). For example, the size of an organisation can vary significantly, from a therapeutic foster family supporting one child to entire institutions working with young people.

2.6.2 Outcomes

Much of the literature relating to outcomes can be split into short-, medium- and long-term outcomes, as discussed by Hart, La Valle and Holmes (2015). These relate to children's short- and longer-term experiences while in TRC, at the point of leaving and beyond the first year of leaving. This study relates to short- and medium-term outcomes, and thus long-term outcome literature has not been specifically reviewed.

When looking at short- and medium-term outcomes, Clough *et al.* (2006) highlighted how young people in therapeutic communities relate their positive outcomes to their ability to relate to others, although highlighted outcomes are often poorly or confusingly described. Gallagher and Green (2012, 2013) looked at medium- and longer-term outcomes for young adults, based on interviews with 16 former residents of a therapeutic children's home in England. They reviewed the literature relating to outcomes for LAC in residential settings,

identifying that there is little data on the process within therapeutic settings and highlighting several common criticisms: specifically, an insufficient contribution from current and former residents (Armour and Schwab, 2005) – an example of a lack of Haigh’s principle of involvement – and the studies having too narrow a scope (Knorth *et al.*, 2008).

Although no reference is made to Haigh’s (2013) core elements, the description of the approach parallels these elements. For example, the theoretical underpinning is one of attachment and psychoanalysis, with attention being paid to ‘containment’ and ‘communication’. Gallagher and Green (2012, 2013) concluded that good outcomes were achieved using a therapeutic residential setting, particularly in relation to emotional and behavioural difficulties. Although this study is limited in its scope – based on a small sample within one organisational setting – it is perhaps the most relevant study for my research.

These findings were similar to Valberg’s (2013) study at Place2Be, a non-residential setting which has a play therapy model with a similar focus as the MBS on developing relationships between children, their peers and staff. The study used nine case studies to explore the value of play in developing therapeutic relationships with children in mainstream settings. The primary-aged boys and girls all exhibited a range of difficulties, including emotional regulation, anxiety and social inclusion, and difficulties with relationships to varying degrees. Although not explicitly stated, these children would be classified as having Type I or II trauma. The study again highlights the relationship between trauma, attachment and relationships. There is evidence that, despite the differentiation of the children, a clearly defined model of play-based therapeutic work supported them to develop and maintain safe relationships. Valberg (2013) recognised that selecting the children on the grounds of ‘perceived parental cooperativeness’ introduced potential bias, and that as a therapist within the setting, her role was that of insider-researcher, something pertinent to this study (see methodology section 3.7.4).

Much of the reason for the lack of standardised assessment models seems to be that few therapeutic settings measure medium- or longer-term outcomes. Brown *et al.* (2011) identified that less than a third of US residential settings measure long-term outcomes; Hart, La Valle and Holmes (2015) found this to be even more acute within the UK.

An early review of the research was undertaken by Hair (2005), who reviewed 11 studies conducted between 1993 and 2003. The review aimed to determine what factors increased the likelihood of positive outcomes for children upon leaving a residential setting. The findings showed that children with severe emotional and behavioural disorders, which matches the diagnosis of those at the MBS, can benefit from and sustain positive outcomes when the residential setting has been multi-modal, holistic and ecological in its approach (Hair, 2005).

The review identified a number of helpful findings which correlate to this study, including the fact that close involvement of the child's family and accessible aftercare programmes for children and families led to an increased likelihood of positive outcomes for the child when they left the setting. Hair's review of literature suggested that the residential programme's philosophy, staff training and supervision, and the therapist–client relationship were potentially important for achieving positive outcomes, and that individual child diagnosis at the point of admission had a negligible impact on outcomes.

However, this review has some differences from the MBS which limit its relevance to this study, beyond looking at context. The study was conducted in the USA with older children, aged 11 to 15, and none of the studies reviewed fit the description of TRC. Additionally, the limited number of studies and the methodological weaknesses of some of those studies – such as variability of participants, lack of comparable information, lack of comparison groups and the use of retrospective data – make this review of interest rather than comprehensively relevant.

Curtis, Alexander and Lunghofer (2001) provide a helpful literature comparison on the outcomes of residential group care and therapeutic foster care. They note significant methodological difficulties in existing reports, making it hard to draw definite conclusions. However, while neither model can be aligned directly to the MBS, they do highlight several relevant points, particularly about the limitations of reviewing the literature. They emphasise that these two models address the needs of different populations of children and, more importantly, that it is necessary to consider that the emotional intimacy of foster families does not always benefit the most traumatised children. Such children may find the intimacy of a family setting overwhelming and are best placed in residential group care. The study does identify research (Chamberlain and Reid, 1998) suggesting that children in therapeutic fostering make significant progress compared to those in residential childcare. However, it is not clear whether this is due to therapeutic input, the family environment or the individual child's background.

Curtis *et al.*'s (2001) study highlighted the lack of emotional and behavioural disturbance being described and the difficulty in comparing child groups. Interestingly, they identify limited evidence that children placed in therapeutic fostering care are more likely to have been physically abused or neglected, while those in residential care are more likely to have experienced sexual abuse. No other study appears to draw conclusions relating to the type of abuse or trauma the children had experienced. Notably, there is no evidence of children at the MBS being more likely to have experienced one kind of abuse over another.

Connor *et al.* (2002) highlighted that most studies use broad measures, such as educational progress, and given the prevalence of emotional disturbance in the residential sector, greater attention should be given to individual outcomes based on clinical outcomes – these could be similar to the MBS's 11 Key Elements. Measures that are more defined relate to

outcomes which are inconsistently defined, making it hard to compare. Also, many of these studies look at short- and medium-term outcomes, rather than long-term (life) outcomes. Given the impact of early-life trauma, consideration needs to be given to what outcomes are being worked towards.

Building on Hair's (2005) review, the most thorough review of the literature is Hart, La Valle and Holmes's (2015) comprehensive overview of residential care for the UK Department for Education, which focussed on evidential outcomes. This again highlighted the difficulties associated with outcome measurement, recognising the limited amount of measurement, particularly for longer-term outcomes (Dooner and James, 2019). One of the limitations identified by this report, which relates to short-, medium- and longer-term outcomes, is the difficulty in comparing outcomes with a control group. Some consistent themes from the study were issues relating to data, bias and the limited availability of information about the quality and specific features of placements. Hart, La Valle and Holmes (2015) highlighted the difficulties in comparing care settings, noting that many focus on a narrow range of adverse outcomes and are often defined purely by service providers, rather than the children or their families. This contrasts with research in other areas of children's policy, where much of the data is collected directly from children (Dooner and James, 2019).

A literature review by the Social Care Institute for Excellence (SCIE, 2012) looked at therapeutic models related to social work in residential childcare settings to describe the origins, content and evidence base of the models and analyse the similarities and differences between them. The seven models, which include the aforementioned Sanctuary Model™, were reviewed against several underpinning concepts (see table 2), some of which map against the MBS's model.

Underpinning concepts	Sanctuary	ARC	CARE	MAP	BCC	Resilience	Social Pedagogy
Attachment theory	X	X	X	X	X	X	X
Trauma-informed	X	X	X	X	X	X	
Neurodevelopmental	X		X	X			X

Table 2 Therapeutic models mapped against underpinning concepts

Findings suggest that the Sanctuary, CARE (Children And Residential Experiences) and MAP (Model of Attachment Practice) models most closely relate to the model used by the MBS, with attachment, trauma and neurodevelopmental theories underpinning their work (Macdonald and Millen, 2012).

The CARE model fits well within the definition provided by Whittaker *et al.* (2015), though it does not explicitly describe itself as a therapeutic model. Developed for children and young people in US residential settings, its guiding principles are that it is relationship-based, trauma-informed and includes family involvement, thus matching many of the principles that inform the MBS model. The CARE model is a research-informed, principle-based, multi-component programme designed to build the capacity of residential care (Holden *et al.*, 2015). The implementation of CARE has seen a decrease in youth-to-staff violence and destructive behaviours, though the impact on peer-to-peer violence and self-harm appears inconsistent (Izzo *et al.*, 2016). There is no outcome evidence relating to the use of CARE on trauma symptoms (Forrest *et al.*, 2018). The model emphasises relationships, staff training and self-reflection. Some authors (Collie, 2008) have highlighted the need for a well-trained

residential workforce, and it is noticeable that the CARE model names this within its principles. This parallels the MBS's commitment to training (Mulberry Bush, 2017a).

MAP is a relatively new model based on seven underpinning principles,¹⁷ all of which closely match the MBS's model. Although no evaluation of the model could be located, the available literature indicates that the principles can be mapped to Haigh's five key elements (Haigh, 2013). The available research (Macdonald and Millen, 2012) suggests that, as a new model, MAP is still developing organically, rather than being written up as a therapeutic model.

One of the most recent models is Buildings Communities of Care (BCC), a trauma-informed, family-involved model. BCC involves the careful linking of systems and process to develop a restorative community environment. The model is grounded in the ARC model (Forrest *et al.*, 2018). However, due to its newness, there has been insufficient opportunity for a full critique of the model, so while the literature suggests it is worthy of consideration, there is currently insufficient evidence to support its application.

The MAP, CARE and Sanctuary models are most useful due to their use of attachment, trauma and neurodevelopmental ideas. Although the Resilience and Social Pedagogy models are of interest, the relevant aspects are intrinsic to the other models, so they were perceived as less useful for this study.

However, several limitations are apparent from the six models reviewed, including the limitations of all six models when working with physical aggression (Macdonald and Millen, 2012). Precise definitions of the phrase 'therapeutic' could not be located for the CARE and MAP models, despite both appearing to be closely aligned to the principles of Haigh (2013)

¹⁷ Behaviour has meaning; early experiences establish a child's internal working model (attachment); biological legacies; children develop through relationships; relationships are a continuing process; we understand ourselves in relation to others; and enduring change in behaviours occurs when there is change in a child's internal working model.

and to Whittaker *et al.*'s definition (2015). The review found few studies that empirically investigated the outcomes of the models, though helpfully identified that a lack of evidence regarding effectiveness is not the same as the models being ineffective.

The phrase 'evidence-based practice' (EBP) is often linked to TRC provision. James, Alemi and Zepeda (2013) argued that using EBP both encourages and supports improved outcomes. Both Whittaker (2017) and James (2011) identified compelling evidence to suggest that EBP is effective at improving outcomes (Dooner and James, 2019) in TRC. Forrest *et al.* (2018) highlighted the need for a trauma-informed residential programme which integrates clinical interventions, milieu therapy and behaviour management into one model. While there is evidence that the MBS model offers these components, this is not articulated in the same manner as the other models.

2.7 The use of reflective practice

Maybe reflective practices offer us a way of trying to make sense of the uncertainty in our workplaces and the courage to work competently and ethically at the edge of order and chaos. (Ghaye, 2000, p.7).

The psychodynamic approach adopted by the MBS can have a pronounced emotional impact on staff working with children who have experienced trauma (de Thierry, 2015), and a reflective culture is considered vital to enable staff to make sense of the often adverse effects of the children's presenting behaviours (Turberville, 2013).

Hawkins and Shoet (2006) suggest that even the most competent workers can be reduced to severe doubt about themselves and their abilities as a result of absorbing the emotional disturbance of those for whom they are working. Within the MBS, staff are subjected to this unconscious emotional disturbance daily, and this can lead to vicarious trauma (Pearlman

and Saakvitne, 1995). A sophisticated model of staff support structures enables staff to make sense of these processes and continue to work effectively with the children (Sharpe, 2006). Staff work closely in their teams to share the emotional impact of the work, to make sense of the children's communication and to process the impact of it, similar to a mother responding to and making sense of the distress of the baby. This system of staff support sits at the heart of the school's culture of reflective practice, enabling staff to question their reactions and behaviours, as well as that of their professional peers, to improve practice and achieve greater understanding of the children's behaviour (Turberville, 2018). Staff reflection allows projections and transference to be recognised, understood and worked with, rather than purely felt.

The range of articles supporting the use of reflective practice in schools is overwhelming (Hébert, 2015), with some authors (Farrell, 2012) noting that the phrase has become almost mandatory across education. 'Reflective practice' carries multiple meanings, often lying between learning and thinking (Moon, 2004), and it is commonly used as an umbrella term to signify something good or desirable. All workers carry their understanding of the concept (Smyth, 1992).

The MBS's reflective practice is perhaps most easily understood using the ideas of Donald Schön, who introduced the concepts of 'reflect-in-action' and 'reflect-on-action' in his influential texts *The Reflective Practitioner* (1983) and *Educating the Reflective Practitioner* (1987). 'Reflect-in-action' explains how an individual does an action (makes a move) and how that action subsequently produces an effect on the individual's situation. This effect provides feedback about the situation, enabling the individual to alter or modify their actions and continue within the situation through a new action (move), creating an internal (ideas) and external change (the situation). This creates new ways of thinking about the situation. 'Reflect-on-action' is the process the individual engages with after the event, through reconstructing the experience based on what can be recalled. It allows the individual to step

back into the situation for the purpose of understanding what occurred and what can be learned from the experience.

Schön introduced the idea that reflection could occur either during or after an event – a challenge to earlier and later models of reflection, such as Gibbs (1988), whose ideas have been strongly associated with social work and education, and who proposed that reflection and learning predominantly occur after an event. Schön termed the phrase ‘reflective practitioner’ for those who have the capacity to reflect-in-action and reflect-on-action, and who are aware of the conversation they are having with the situations when they are trying to make a change. He discussed the need for the practitioner to:

[allow] himself to experience surprise, puzzlement, or confusion in a situation which he finds uncertain or unique. He reflects on the phenomenon before him, and on the prior understandings which have been implicit in his behaviour. He carries out an experiment which serves to generate both a new understanding of the phenomenon and a change in the situation. (Schön, 1983, p.68)

While other models describe a prescriptive, step-by-step process to reach ‘reflection’, Schön’s work proposed a framework for thinking without the dependence on a prescribed process. This idea of reflective practice can be summarised as follows:

Reflective practice is learning and developing through examining what we think happened on any occasion (...) opening our practice to scrutiny by others and studying texts from the wider sphere. (Bolton, 2005, p.7)

It is this approach which sits at the heart of the MBS’s approach, encouraging staff, children and families to develop their reflective capacity.

The use of reflective practice supports the development of a more in-depth understanding of work in education (Cottrell, 2015; Dewey, 1933; Schön, 1987). It allows practitioners to develop an awareness of themselves, of hidden motivations and of how they can present to others. As such, it is a way to implement psychodynamic theory into practice, enabling practitioners to become aware of their unconscious actions and feelings. In a turbulent setting such as the MBS, it can often be hard to maintain this level of reflection; the intense feelings of the children can be so overwhelming that staff may find it hard to stay aware of their own unconscious responses, becoming almost paralysed emotionally. It is precisely because of this turbulent environment that reflection is essential to make sense of complex situations, ambiguity and uncertainty (Høyrup, 2004).

Despite extensive support for the use of reflective practice, there is limited evidence that it improves outcomes, and there are numerous criticisms. Most notable is the over-reliance on instinctual feeling (Hébert, 2015). Ferry and Ross-Gordon (1998) identify an inherent difficulty with Schön's model of reflection-in-action: they highlight that the model is a natural process which stems from competencies the worker already possesses, and despite there being opportunities to learn about and practise reflection, some workers might remain unreflective. At the time of writing, the MBS is involved in an external research project to determine the benefits of its reflective culture. The findings are expected to be published in 2020.

Schön's work also attracted criticism from Boud and Walker (1998), who argued that Schön's analysis ignores critical features of the context of reflection. Eraut (2004) maintained that the work lacks precision and clarity, while Greenwood (1993) suggested Schön fails to give sufficient consideration to reflection-before-action. Both Moon (2004) and Ekebergh (2007) challenged whether reflection-in-action was feasible and whether workers needed to remove themselves from the situation to reflect retrospectively. This proves a constant

challenge for staff within the MBS. Given this level of criticism, questions have been raised (Finlay, 2008) about how Schön's work has been applied in professional practice and whether it is appropriate for adoption, with a suggestion that a more critical, reflexive exploration of reflective practice may be required.

Reflective practice has also faced criticism for its reliance on people 'learning to reflect'. It cannot be set out as a set of skills to teach; the development comes through the experience. This raises questions such as: 'At what point do practitioners become reflective?', 'Can this be identified?' and 'How can this be identified?' (Roberts, 2009). The role of reflective practice is further complicated by the subjective nature of the staff's interpretation of unconscious events. The model is reliant on these unconscious processes being brought to the fore so they can be worked with. The MBS has developed models to enable this, but these depend on the ability of staff to use them, and on their level of comfort with discussing emotional aspects of themselves with others, particularly in group settings.

Some of these criticisms may be ameliorated by the development of a reflective culture across the MBS (Turberville, 2013), rather than the 'bolt-on' reflective practice often seen in education settings (Roberts, 2009). Staff attend regular reflective spaces, but these form just a small part of the culture of reflection which permeates the organisation, and which is the subject of ongoing research. The culture exists across all departments and requires careful monitoring and thought. When working alongside the children, it can be too easy to lose sight of the reflective culture and become purely responsive to the children's, often extreme, behaviours.

2.8 Collaborative working

Collaborative working is a core principle of the MBS, as I have outlined above (p.20). While the MBS literature does not specifically define collaborative working, it does identify that, in the MBS context, it involves placing the child's needs at the centre of the work, while recognising that dynamics and relationships between teams, families and professionals provide an insight into children's needs (Agudelo, 2018; Turberville, 2018). It can therefore be understood as a central part of the therapeutic approach of the MBS.

In practice, this draws on therapeutic community principles (discussed on p.17) to bring staff from different professional backgrounds and levels together from across teams to consider the impact and dynamics arising from the work (Turberville, 2018). The model is extended to the work done with families and external professionals as a means of understanding the child in their broader context (Agudelo, 2018; Browner and Onions, 2014). For example, dynamics between teams, families and external professionals are sometimes understood as a reflection of the child's unconscious communications (Ward, 2007). In this way, a dynamic of poor communication and blame between education and care staff teams may be understood using Klein's (2011) idea of splitting (discussed on p.46), reflecting the child's unconscious need to prevent adults from working and communicating closely. It is often these underlying dynamics between professionals which are seen to prohibit effective working together (Ward, 2007).

This understanding of collaborative working differs from how it is understood more generally in the childcare field, where the term is usually taken to refer to interagency working, with much of the literature focussing on multidisciplinary working between education, health and social services. 'Collaboration', as Frost (2005, p.14) suggests, refers to one level in a hierarchy of four, with co-operation, the weakest and loosest form of working together, at

one end, and integration, which occurs when different services merge for better service delivery, at the other. Collaboration is one level higher than co-operation, with services agreeing common goals and outcomes, and planning together to achieve a more efficient service. This understanding of collaborative working can be considered as, principally, a feature of service management, and this is in contrast to the MBS's understanding, according to which management relations are just one part of the overall therapeutic approach. The management relations involved in the MBS model of collaboration with external services are closer to Frost's (2005) description of 'complex collaboration', with shared responsibility for tasks and decisions being essential (Barnes and Melhuish, 2017).

Theoretically, collaborative working is a natural extension of working psychodynamically. Within the MBS, collaborative working can most easily be understood as a development of systems theory, with the emphasis on the different parts being interconnected and affecting one another (Richardson, 2003). The role of systems theory, or systems thinking in group care, has been well documented by, among others, Ward (2007), who highlight the links between systems thinking and psychodynamic thinking in terms of unconscious processes, or patterns and histories within relationships. Ward (2007) recognises the complexity of group care settings, arguing that, by its nature, systems thinking is a more complex theory and thus is better suited to application in group care.

There are several criticisms of systems thinking, many of which can be considered in relation to the MBS. Cottone and Greenwell (1992) argue that looking at the sum of the parts runs the risk of failing an individual perspective; this is ameliorated within the MBS, where there is an expectation of and reliance on family involvement in the treatment plan for each child. There is evidence within the school (Browner and Onions, 2014) that, where families fail to engage with the child's therapeutic treatment, progress is significantly reduced, and for some children this can lead to placement breakdown. Further criticisms suggest a failure to

acknowledge the human need for power within relationships (Dell, 1989), though this is something the school addresses in its work with families (Agudelo, 2018). However, these criticisms are not specifically related to residential childcare and are challenged by Spronck and Compennolle (1997), who argue that they are misdirected and focus on outdated models of systems theory.

Such models include family systems thinking (Byng-Hall, 1995), and examples which directly relate the ideas to residential therapeutic community work (Richardson, 2003) highlight the value of involving families in the treatment of children in care. However, the MBS's model takes this further, looking at the professional network engaged with each child and family as an extension of the child's 'system' (Agudelo, 2018). This model of working collaboratively, or systemically, can be seen to directly correlate to the therapeutic community model (Ward, Kasinski, Pooley and Worthington, 2003), and within the MBS this relates to internal and external professional networks (an outline of the internal networks is given in chapter four).

2.9 Living and learning together – the group-work model

In addition to the three core principles, the school places significant emphasis on the group-work model. This comprises small groups – for example, class groups of up to ten and house groups of up to 18 – complemented by whole community groups of up to as many as 110 children and staff, based on the current staff team. The literature suggests that when the school was a smaller community, up to 40 individuals, the larger group-work model was used (Dockar-Drysdale, 1990). The idea of living and learning together is not unique to the MBS; it has long been adopted by settings looking for a model other than the dyadic doctor/therapist–patient relationship.

Such models of working with children stretch back to the early part of the twentieth century and the work of Homer Lane, who established the Little Commonwealth community in 1914

(Wills, 1964). Within adult settings, this model stretches back even further and is widely used within certain cultures, for example, Quakerism. Over the last century, the model has developed to be more applicable to children and young people (Ward *et al.*, 2003).

As previously mentioned, Diamond (2018) highlighted that for many of the children placed in the MBS, the intensity of family relationships can be overwhelming, leading to the breakdown of previous foster care placements. A group-based approach allows the support to be more widely spread, but not diluted; to be available day and night, rather than in shorter, often more intense therapy sessions; and to provide a sense of 'safety in numbers' (Button, 1997). The use of the large group allows these social relationships to be used in the 'pursuit of therapy' (Harrison, 2018). If relationships form the central component of psychodynamic work, then it should be argued that, in a residential setting, greater significance needs to be given to the group (Sharpe, 2006). This will enable an environment in which children can feel 'emotionally held' by others and work can take place within these relationships.

Despite considerable support for the group-work model and therapeutic community principles (Clough *et al.*, 2006; Sharpe, 2006; Ward *et al.*, 2003), there is limited evidence for the effectiveness of this model. One criticism questions the impact on traumatised children of living alongside the trauma of others, and whether this might lead to retraumatisation or vicarious trauma (Pearlman and Saakvitne, 1995). This study hopes to alleviate these criticisms, and the day-to-day application of the group-work model is discussed further in chapter four (Clough *et al.*, 2006; Sharpe, 2006; Ward *et al.*, 2003).

2.10 Summary

This chapter has explored the theoretical ideas which inform this study and reviewed the evidence for whether therapeutic settings benefit emotionally traumatised children. It has reviewed several psychodynamic theories, which I shall be drawing on in my analysis of the data, pointing to what I consider to be valuable insights and significant limitations. I looked at the concepts of reflective practice and group work, and these too will be returned to for data analysis.

Perhaps the most significant outcome of this review is the idea that there is limited evidence that therapeutic settings offer greater benefits for traumatised children than standard residential settings. However, the research provides indicative, but not definitive, evidence of the positive effects of therapeutic residential care. Data issues consistent in almost all the studies include a lack of control for selection bias and a lack of information about the quality or features of placements. It is difficult to isolate the specific effects of a care placement, or to draw comparisons with other settings, as there is no research relating to primary therapeutic residential settings for severely traumatised children. Much of the literature is beset by methodological difficulties, a lack of differentiation between populations and settings, and a lack of definition for the term 'therapeutic'; all this limits the extent to which the literature can be compared with the MBS.

The literature relating to the MBS indicates that children make significant progress socially, behaviourally and academically, indicating that they benefit from the school's unique provision. However, most of the literature pertaining directly to the MBS is written by its own staff, which imposes limits on its impartiality and objectivity, as discussed in chapter two. Independent research identifies the progress made by children at the school, but these

studies are based on small samples, and, as with other evidence on therapeutic childcare, the data cannot easily be compared to data from different therapeutic settings.

It is apparent that, while there is extensive literature on working with children in residential care, few studies explore TRC, and none explore the role of a group-work model in a TRC setting.

This review demonstrates the considerable scope for more research in the area I have chosen to explore. In the following chapter, I present my methodology, demonstrating how I propose to add to the existing evidence and literature.

Chapter Three: Methodology and design

3.1 Introduction

In the previous chapter I undertook a review of the literature related to the study, exploring sources specifically related to the MBS, the theoretical models informing this thesis, emotional trauma in children and therapeutic residential childcare. There was limited UK-based literature relating to the study area, particularly from authors external to the school and in peer-reviewed publications. Although literature was identified which explored specific aspects of all these areas, there was a limited amount of literature which related them to one another. The literature review identified a 'dearth of research' (Gallagher and Green, 2013) regarding the benefits of therapeutic settings.

The purpose of this study, therefore, is to add an urgently required dimension to the literature by examining the model of therapeutic childcare developed by the MBS, to explore the evidence for benefits and shortcomings through in-depth research. Taking a case study approach, this study seeks to generalise to theory building, making a significant contribution to academic discussion within the therapeutic childcare sector, providing an important exploration of 'what it is like' for children placed at the MBS and advancing the theories which underpin therapeutic childcare.

At the heart of this qualitative study is the idea that phenomena are socially constructed by individuals in relation to their world, i.e. their experiences and their environment (Merriam, 2007). Therefore, this study's foundations are the experiences and stories of the children, parents and carers and staff, which together provide a sense of the 'complexity and richness' (Marshall, 1981) required to understand 'what it is like' for children placed at the MBS.

In this chapter I return to the aims of my study and to the research questions, as set out in chapter one, to discuss the methodology underpinning my thesis and to provide a critical review of how the methodology was selected. I will discuss the type of approach adopted, the design and fieldwork process, how data analysis was performed and the limitations of the methodological approach in answering the research question. Finally, I briefly discuss how I dealt with the ethical dimensions of the study.

3.2 Epistemology and methodology

At the heart of the epistemological aims of this study is the question of what can be learned about the MBS, and how we understand knowledge, its extent and its validity. This study involves understanding the experiences of the children placed at the school, as well as those of their families, carers and staff. This reality cannot be measured but can be understood by adopting an appropriate methodological approach. From the outset, it was necessary to choose a method appropriate to the research question, not a predetermined one (Silverman, 2017). This challenged my need to adopt and work with a clear model, forcing me to consider the true nature of the question and purpose of the study.

The epistemological position taken in this study is that of social constructionism, which led me to adopt a mainstream qualitative approach, with affinities to both phenomenology and hermeneutic approaches (Robson, 1997). This position assumes that the social world is constructed through meaning and interpretation (Gourley, 2009) and that participants, including the researcher, help to construct reality, with an emphasis on developing an understanding of the multiple social constructions of meaning and knowledge, and thus an understanding of knowledge (Robson, 1997). Such knowledge is, therefore, dependent on, and perhaps limited by, the researcher's own subjective experiences; there is not one reality or answer, but an amalgamation of participants' interpretations of the studied reality (Winter,

2009). It is worth noting the example given by Alderson (1999) in relation to children's emotional and behavioural difficulties, which are often linked to childhood trauma: that they are a social construction in the way they are identified, perceived and evoked by relationships and situations. This appears to directly correlate to the understanding of the MBS's approach, and thus to this study.

These ideas about constructing knowledge raise the critical issue of researcher reflexivity, defined by Gibbs (2001, p.697) as 'reflection upon theories, thoughts, feelings, actions, interpretations, assumptions, expected and unexpected outcomes and the development of practice and theory from further reflection'. This definition is extended far beyond the research through the work of Bourdieu and Wacquant (1992), who highlight that it should include a much broader social context, in which it is necessary to consider the structuring effects of the academic field, the researcher's own position within it and the impact on the researcher's beliefs and practices (Kenway and McLeod, 2004). In relation to this study, researcher reflexivity is discussed in greater detail with regard to insider research later in this chapter.

Given that the MBS is the focus of this study, a research approach was needed that would allow subjective knowledge of the MBS, an understanding of real-life events and an acceptance that the work of the MBS is in part defined by its participants – the children, their families and staff – and that there exist multiple realities (O'Reilly and Parker, 2014). The methodology needed to allow the investigation of conscious and unconscious communications within the school and consider experiences from a number of sources, without being concerned with identifying an absolute truth or answer.

One of the underlying issues of this study is understanding the dynamics of the MBS, and the premise that any unit of investigation in which people are involved can only be

understood if the perspectives of those involved are taken into account (Pring, 2004). This underlines the adoption of a qualitative approach to the study. Mason (2006) highlights that the strength of qualitative research lies in the knowledge it provides of the dynamics of social processes, while O'Reilly and Parker (2014, p.251) define qualitative research as the exploration of 'people's beliefs, experiences and perceptions (...) usually conducted with smaller sample sizes. It is concerned with the depth of information.' This depth of information is central to this study and is discussed further on.

The defining characteristics of qualitative research are given by Cassell and Symon (1994, p.7) as:

a focus on interpreting rather than quantification; an emphasis on subjectivity rather than objectivity; flexibility in the process of conducting research; an orientation towards process rather than outcome; a concern with context – regarding behaviour and situation as inextricably linked in forming experience; and finally an explicit recognition of the impact of the research process on the research situation.

Creswell (2017) proposed the following characteristics of qualitative research: an exploratory and descriptive focus, emergent design, data collection in the natural setting, an emphasis on 'human-as-instrument' and early and ongoing inductive analysis. Exploratory and emergent design is one of the most critical characteristics of qualitative research and one which directly relates to this particular study. The idea of regarding 'behaviour and situation as inextricably linked' matches the direct work of the MBS and is discussed in the preceding chapter. These characteristics and considerations led to the adoption of a qualitative approach to this study.

The purpose of this study is to capture the complexities of an organisation which is based around interactions and relationships. This study aims to explore the detail of these interactions and contexts to help develop an understanding of the school's activity. The research explores the dynamics and experiences which make up the MBS and is an empirical investigation of a contemporary phenomenon within a real-life context (Yin, 2014). Thus, a case study approach is the most appropriate methodology, as supported by Yin's (2003, p.xi) assertions that case study research is appropriate when researchers hope to: '(a) define research topics broadly and not narrowly, (b) cover contextual or complex multivariate conditions (...) and (c) rely on multiple and not singular sources of evidence'.

A case study is not necessarily a choice of method, but more a choice of what will be studied, or a strategy for undertaking research (Yin, 2014). The name 'case study' is emphasised by some researchers because it draws attention to the question of what specifically can be learned about the primary case – in this case, the MBS. It places importance on the design to optimise understanding of the case (Stake, 2005); the primary consideration when selecting a case should be to 'maximise what can be learnt' (Stake, 1995).

3.3 A case study approach

Case studies are the preferred strategy when 'how' and 'why' questions are posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context. (Yin, 1994, p.1)

The research approach selected was the case study – one of the most common ways to undertake a qualitative enquiry (Stake, 2005). It was acknowledged that case studies are not

a method or methodology, but provide a flexible strategy for conducting research (Candappa, 2016). The case study approach was selected as it would allow the research to capture the complexity of a primary case, the MBS, by investigating a phenomenon in its real-world context, and this would be particularly appropriate given that the boundaries between context and phenomenon are not evident (Yin, 2014). Case studies are particularly suitable for examining social events and behaviour, paying attention to the associated contextual and experiential meanings, and for developing what Geertz (1973) referred to as 'thick description'. Geertz (1973) used this term to refer to a detailed description of behaviour, often resulting from ethnography, which would allow the researcher to see below appearances, providing commentary and interpretation (Geertz, 1973).

The case study approach was also chosen because it is associated with the exploration of processes and dynamics of practice, and because it was important to this study to understand the organisational context. Context is a crucial element in qualitative research in general, and case study research in particular, because it situates the case within its setting – whether physical, social, historical or economic (Creswell, 2017). Case study research is well suited to allowing researchers to gain an in-depth understanding of a case (Bromley, 1986) and has been widely used in education research (Mitchell, 1983), as well as in the fields of health and social sciences (Yin, 2014), again making it highly appropriate for a study based within a therapeutic special school. Indeed, it has been argued that case studies are often the most suitable format for school-based research (Hitchcock and Hughes, 1989).

The research design provided a 'good fit' to the fundamental concepts of case study research, with an emphasis on 'how' and 'why' questions, while a contemporary set of events is explored, with little known about the phenomenon being researched (Yin, 2014). As with other methods, the case study allows for the development of a rich and detailed narrative, or 'thick description' (Geertz, 1973).

Yin (2018) has provided a well-regarded account of the case study approach, emphasising its importance for developing theory, complementing other prominent methodologists, including Stake (2006) and Merriam (2007). Yin (2018) argued that the case study model is particularly suitable in research when it is not possible to separate the boundaries of the phenomenon under investigation, or where the context is not clearly defined – such as with the MBS and the children who are placed there.

These considerations also highlight the issue of boundedness, and the boundaries of the case, which required careful consideration. Many prominent case study authors (Stake, 2005; Yin, 2014) have discussed the notion of boundedness as a core concept, noting that the boundaries are circumscribed by the research questions, and thus case studies differ from other qualitative methods. In relation to this study, the boundaries of the case are taken as the aspects of the school bounded by the therapeutic approach. The participants in this study all have different relationships, different professionals and family members – for example, some have regular contact with their birth families, while others do not.

The research also needed to be open-ended, narrative and holistic (Greene and Hogan, 2005) to allow me to create detailed pictures of the school and of each child – their lives, experiences and relationships with those around them. Such an approach allowed for flexibility throughout and emphasised the need to listen to each child's account, to hear what they had to say rather than to rely only on what had been said about them, and thus to recognise them as experts on their lives (Clark and Moss, 2017). This approach used a wide range of tools to enable the children to share their views (Punch, 2002a) and to enable me as a researcher to 'view the world through the lens of the children' (Johnson *et al.* 1998) and to acknowledge their points of view, or potentially their right to remain silent (Clark and Moss, 2017).

3.3.1 *Limitations*

One aspect of qualitative studies is that the researcher becomes the principal instrument for collecting and analysing data, which can be a strength and a limitation (Merriam, 2007). On the one hand, the intimate relationship developed between the researcher and the central phenomenon, and the collection and analysis of data, clearly lend a human element to the research, allowing for depth of description and of understanding. On the other hand, it also raises a critical limitation: the need for the researcher to be aware of and reflect on their position, assumptions and beliefs. Merriam (2007) highlights that qualitative research is only as good as the researcher's own qualities, such as tolerance for ambiguity, intuition and the need for excellent communication skills. While I believe I have evidenced these, it must be acknowledged that throughout the study these skills have been tested. The use of supervision and of my own reflective journal throughout the research process has helped to ameliorate these issues. This is explored further on in relation to researcher reflexivity.

Many of the limitations of this study are also the perceived limitations of case studies in general, namely: typicality, generalisability, representativeness and subjective bias. Much of this criticism links to a misunderstanding of where case studies sit. Stake (1995) reminds us that case studies do not attempt to advance grand theories, but rather to give insight into situations. This was a helpful clarification to hold in mind while developing the methodology, as were the five key misunderstandings about case study research highlighted by Flyvberg (2006).¹⁸ These are the most widely regarded counter-arguments to the critiques of the case study, identifying new perspectives and providing up-to-date counter-arguments to widely held criticisms of qualitative research (Taylor and Francis, 2013), and they informed the design of this study.

¹⁸ These are: '(1) Theoretical knowledge is more valuable than practical knowledge; (2) One cannot generalize from a single case, therefore the single case study cannot contribute to scientific development; (3) The case study is most useful for generating hypotheses, while other methods are more suitable for hypotheses testing and theory building; (4) The case study contains a bias toward verification; and (5) It is often difficult to summarize specific case studies.'

Perhaps the most common of these criticisms is the perceived lack of knowledge and generalisability (Yin, 2014) which can be drawn from single or small numbers of cases (Candappa, 2016). However, Yin (2003) and Flyvberg (2006) both highlight that case studies are generalisable to theoretical propositions, not to populations, and that in undertaking a case study the researcher's 'goal will be to generalize theories (analytical generalizations) and not to enumerate frequencies (statistical generalization)' (Yin 2003, p.10). Throughout this study, there were no attempts to develop scientific generalisations, but rather to build thorough knowledge of a particular phenomenon (Stake, 2005).

Case studies are often criticised for confirming or verifying the researcher's preconceived notions (bias), thus questioning their scientific value (Diamond, 1996). Sufficient evidence exists, however, to suggest that, rather than verifying bias, case studies allow the researcher to identify whether preconceived hypotheses were incorrect and to revise them if necessary (Flyvbjerg, 2006). Flyvberg also argues that the case study contains no more significant bias towards falsification of preconceived notions than towards verification, suggesting that there is, in fact, no evidence of any higher level of bias in case studies than any other form of research (Flyvbjerg, 2006).

As a researcher, I was acutely aware of the impact of bias, which often arises through poorly articulated questions (Treece and Treece, 1974), particularly during the interview and focus group stage of data collection. My insider-researcher role may have increased bias, as my greater familiarity and prior knowledge may have led to unconscious assumptions about the research process (Hewitt-Taylor, 2002). An 'objectivist' stance would argue that all data impacting variables, including prior knowledge, should be eliminated (Winter, 2009). However, this point has been argued against by Bourdieu (1999), who claimed that prior knowledge can bring out the realities of the research being explored. Thus, I took the viewpoint that my knowledge was an advantage, giving greater insight into and

understanding of the context of the care, though I was mindful of the blurring of boundaries.

The final misunderstanding about case studies which is challenged by Flyvberg (2006) is that they are particularly challenging to summarise. There is some truth that the process can be hard to summarise, but this should not impact the summarising of outcomes. Flyvberg (2006) proposed that this is not a limitation of the case study approach itself, but more often of the properties of the study (Flyvbjerg, 2006), and that this is not necessarily a limitation, but rather a good case study should be read in its entirety as a narrative.

In light of these potential limitations, I used the following strategies to enhance the overall credibility of this case study (Sturman, 1997, p.65):

- Procedures for data collection should be explained
- Data collected should be displayed and readied for reanalysis
- Negative instances should be reported
- Biases should be acknowledged
- Fieldwork analyses need to be documented
- The relationship between assertion and evidence should be clarified
- Primary evidence should be distinguished from secondary evidence, and description and interpretation should also be distinguished
- Diaries or logs should be used to track what was done during different stages of the study
- Methods should be devised to check the quality of data

The work of Lincoln and Gubba (2000) highlights that the burden of proof should be on the user, not the researcher, so that, provided there is sufficient 'thick description' (Geertz, 1973), the user can draw their conclusions.

3.4 Design of the study

Research design can be described as the ‘argument for the logical steps which will be used to link the research question(s) and issues to the data collection, analysis and interpretation in a coherent way’ (Hartley, 2004, p.326). This study is based upon ‘practice-near’ research methods, which build on the distinction between experience-near and experience-distant enquiry (Geertz, 1973). Practice-near research in human service contexts is informed by ‘methodologies that include “thick” description, intensive reflexivity and the study of emotional and relational processes’ (Froggett & Briggs, 2012, p.1), and thus it has a strong correlation to the case study approach.

This research was designed to build upon Yin’s (2003) five components of research design, which he identified as having particular importance, and which are discussed throughout this section:

- The study’s questions
- The identifying propositions, if any
- The study’s unit(s) of analysis
- The logic linking data to the propositions
- The criteria for interpreting the findings

Initially, there was a need to identify the type of case study to be used. Three main types of case study have been identified: intrinsic, instrumental and collective (Stake, 1995), although these are not mutually exclusive. This study focusses on a primary case, or unit of analysis (Merriam and Tisdell, 2016), within which are the four embedded units, or cases within the case (Scholz and Tietje, 2002; Yin, 2003). It is important to recognise that the term ‘embedded case study’ refers to the individual units embedded within a larger case, and that each of these embedded units represents the case of one child. The embedded units are regarded as ‘instrumental’, as they lead to the understanding of the primary case, but are not

the sole focus of the case study (Stake, 2005). My aim was to develop an understanding that extended beyond the individual participants, through an insight into how therapeutic work may benefit traumatised children. However, as an employee of the MBS, I have to accept that I have an 'intrinsic' interest in the primary case.

The critical factor determining an embedded design in this study was the nested nature of the context: the purported benefits of attending a therapeutic school are nested, or embedded, within the overall context of the MBS. Using embedded units enabled me to explore the primary case while considering the influence of the children, their families and the staff upon the case. This approach held several advantages, as highlighted by Baxter and Jack (2008, p.550), who argued that 'the ability to engage in such rich analysis only serves to better illuminate the case'. It allowed me to analyse the data within the embedded units separately (within-case analysis), between the embedded units (between-case analysis) and across them (cross-case analysis).

However, consideration also needed to be given to how the cases would be analysed, as Yin (2003) highlighted that novice researchers often fall into the trap of analysing the embedded units but failing to return to the overall case. This is a valid concern, especially where the embedded units are people and where relationships exist. To not lose sight of the primary case, the discussion of findings for this study was designed to return to the MBS.

3.4.1 The case and the embedded units

The appropriateness of the embedded unit selection process would heavily inform the value that could be derived from the case study (Newton, 2003). Thus, the selection design and implementation were carefully constructed. The embedded units needed to be selected to provide the most reliable data, being careful that they were not too divergent in their parameters that they became difficult to compare and analyse, yet not too similar that they

failed to yield the sought-after depth of understanding.

Four 'information-rich cases' – that is, cases which would give a good depth of knowledge (Patton, 2015) – were selected from the school's pupil population (25 when the study commenced). Four was considered sufficient to yield an in-depth understanding and provide the required insights without creating an unmanageable quantity of data. Two 'reserve cases' were identified to compensate for potential attrition, while an additional pilot case enabled testing of the data collection instruments.

For this study, a purposive sampling strategy was utilised in the selection of embedded units to maximise what could be learned (Stake, 1995). This is one of the most commonly used models for selecting qualitative samples, and it is most helpful for identifying and selecting information-rich cases and for most effectively using limited resources (Patton, 2015). It uses predetermined criteria based upon the research questions (Miles and Huberman, 1994).

This study required identifying and selecting individuals or groups which would be especially knowledgeable about, or experienced with, the phenomenon being studied (Creswell and Plano Clark, 2011). Bernard (2002) highlights the importance of knowledge availability, willingness to participate and the ability to communicate experiences and views. This contrasts with other sampling models, such as probabilistic or random sampling, which are often used to ensure the generalisability of findings by minimising the potential for bias in selection, and to control the potential influence of known and unknown confounders (Palinkas *et al.*, 2015), which were felt to be inappropriate for this study.

The embedded units were identified based on the following selection criteria, which would allow the identification of individuals to inform an understanding of the research problem (Creswell, 2018):

- Gender
- Age (5–12 years)
- Residence (with birth, adoptive or foster families)
- Duration into placement
- Whether involved in other research projects

Having identified a number of appropriate children, consideration was given to the potential for each child, and their family, to participate in the research in an emotionally safe and contained manner. At this stage, it was essential to obtain guidance from the school's placement manager, to ensure that the placements were not at immediate risk of ending, that the research was not likely to prove emotionally harmful to the child or their family, and that there were no known legal ramifications, given that many of the children were looked after children and in the care of local authorities. However, the overall selection of cases remained my own.

One of the most significant anticipated threats to the research was attrition: the number of cases reducing due to the premature termination of a placement. Should any of the children leave the school, it was intended that they would continue to be part of the research, that previously gathered data would remain valid and that post-placement interviews would be undertaken, which would be built into the initial information sheets. If children were to leave the school, and the parents or carers did not allow their continued involvement, the number of cases would be reviewed and the reserve cases utilised.

3.4.2 Participants

The participants in this research were the parents and carers, staff, children and members of the school management team during an 18-month fieldwork period (table 3). Including the pilot study, this included six children: two who resided with birth parents, two who had been

adopted and two who were fostered. One child withdrew from the study shortly after the first period of data collection. Subsequently, one of the previously identified children took their place.

Of the five parents and carers, four were interviewed as couples and one was a single woman. The foster carers were all experienced and intended to continue with a long-term placement with their foster child. All the participants described themselves as white British, which also reflects the overall ethnicity of the MBS staff team, though not the child population. All the parents and carers resided in southern and south-east England.

Participant	Family placement	Gender	Age at start of data collection
Pilot – Duncan	Adopted	Male	9 years, 2 months
Angie (withdrew)	Fostered	Female	9 years, 7 months
Leo	Birth family	Male	10 years, 6 months
Lola	Fostered	Female	7 years, 4 months
Jamie	Adopted	Male	9 years, 10 months
Reserve 1 – Kerry	Birth family	Female	10 years, 11 months

Table 3: Participant placement type, gender and age

3.4.3 *Studying the case*

The use of qualitative methods enabled the participants (and myself as a researcher) to explore questions and issues in depth, allowing for the exploration of, sometimes unexpected, avenues of enquiry that were not always anticipated, giving greater depth to the data. By definition, using the case study approach across multiple sources of data allows for the development of converging lines of enquiry (Yin, 2014), as well as providing different

ways in which the phenomenon can subsequently be seen (Silverman, 2017).

Next, consideration was given to the most appropriate methods for data collection. The principal means of data collection were intended to be: literature relating to the MBS, archival data and documentation, informal observations, semi-structured interviews and focus groups. The limitations of these methods were considered (discussed below), and it was anticipated that many would be overcome through a triangulation of the methods, ensuring reliability and validity (Yin, 2003) and supporting the stability and quality of the data and subsequent analysis (Sapsford and Jupp, 1996).

Although children are placed at the school for approximately three years, data collection was designed to take place over 18 months, with staggered collection points to reflect different periods of the children's placements. It was important to consider how significant amounts of data would be brought together and stored in a comprehensive and organised manner so it would be easily retrievable at the point of analysis. Yin (2014, p.238) refers to this as the case study database, 'a systematic archive of all the data (...) from a case study', which he differentiated from the final case study report.

3.4.4 Sources of evidence

The primary case used multiple sources of evidence: literature, in the form of archival data and document analysis, semi-structured interviews and the building of the embedded units. The latter used multiple methods of data collection built around a clear case study protocol, allowing for the development of converging lines of enquiry, a process Yin (2014) describes as triangulation. Together, this enabled the building of the 'thick description' (Geertz, 1973) required to explore the details of the case, including the children's social worlds, as well as and the narrative they would provide. These methods are discussed below.

3.4.4.1 Archival data and document analysis

There is a longstanding tradition of documentary enquiry which, over time, has evolved to include new data sources, such as the internet, leading to document analysis becoming more common (McCulloch, 2004). For this research, archival data and documents were selected as they offer several benefits, most significant of which is that they are stable and can be reviewed repeatedly (Creswell, 2018). They were not created as a result of the case study, and as such they were unobtrusive, and their contents were expected to be exact and less open to interpretation, including by my own potential insider-researcher bias, discussed further on in this chapter. The documents allowed contextual data to be gathered and synthesised before the interviews were undertaken.

Chapter two's literature review helped to identify a range of MBS documentation, which was further analysed as part of the documentary evidence process. This included historical trustee reports, practice guidance documents, strategic plans and reviews and unpublished papers written by MBS staff.

For the embedded cases, the review covered the entire life history of each child, and included a range of educational, social and health reports or assessments, augmented by internally written reports, observations, assessments and correspondence, including academic assessments, assessments of emotional development, Personal Education Plans (PEPs) and psychological and psychiatric assessments. These were used to build a background of the children's lives and identify significant life events and periods of professional involvement.

The analysis of this archival data and documentation was based upon the four criteria developed by Scott (2006): authenticity, credibility, representativeness and meaning. The authenticity and origins of the materials were considered, including professional background,

authorship, date and whether the documents had been edited by other authors – for example, where reports were completed jointly by multi-disciplinary professionals. Relevant extracts were recorded on the case study database, indicating the period they related to and the type of document. Only when these fundamental criteria had been established did further documentary analysis occur.

Subsequently, documents were appraised to determine their credibility, honesty and accuracy. Often, narrative documents are unintentionally inaccurate (Scott, 2006) and any written documentation is likely subject to the author's bias. Professional documents can be subject to their own bias and shortcomings (McCulloch, 2004), and this study brought together reports from several professions, each with their own bias, including the potential for my own as insider-researcher. Consideration was also given to the purpose of the documents and the audience for whom they were written, such as other professionals or families. It was anticipated that some documents would provide conflicting information which would require clarification through the interview process. These conflicts were viewed as rival explanations and considered part of developing a deeper understanding of the cases.

Scott's (2006) third criterion, representativeness, seeks to establish whether the documents used are typical of such accounts and reliable, though Scott also highlighted that the researcher might never be able to determine whether documents are fully authentic, credible and representative. In this case, Scott's (2006) suggestion of the author reversing the process was beneficial, asking whether the documents were inauthentic, non-credible or unrepresentative.

The final criterion refers to whether the evidence is clear. While these criteria were felt to be fundamental to the process of documentary analysis, McCulloch (2004) has highlighted a further criterion, 'theorisation' – the anticipated theoretical, hermeneutic framework for

interpreting the material – which would also be used.

3.4.4.2 Ethnographic observations

The archival data and documents were supported by observations, an often-used method of data collection in both qualitative and quantitative studies of children (O'Reilly and Parker, 2014), which were chosen as they would prove helpful in developing an understanding of individuals and social groups or cultures.

As an employee of the school, and thus an insider-researcher, it was both unnecessary and inappropriate for me to undertake structured participant observations of the children, despite this method being widely applied in case study analysis (Silverman, 2017). Although observations of practice are commonplace within the school (Turberville, 2013), these are often based on looking at specific behaviours or interactions between staff and children, and were not felt to be the most appropriate method of data collection for this study, due to their narrow scope. However, given my dual role in the school, I already have extensive familiarity with the school's work, and thus am already immersed in the context of the study. This meant that an informal ethnographic approach would be beneficial, providing a descriptive interpretation of the culture (Robson, 1997) of the school. An ethnographer's task is to become an accepted member of a group/community, and so this provided me with an advantageous position from which to undertake the research. This approach has faced concerns about researchers getting over-involved (Robson, 1997), but it does produce 'thick description' (Geertz, 1973), and it is no longer unusual for researchers to be 'insiders', particularly in schools (O'Reilly, 2009). The informal ethnographic observations were recorded, descriptively and reflectively, after all interactions with the children, whether connected to the research or not, with attention given to time and place – an often-neglected area of case study observations (Yin, 2004) – as well as details of what was observed, spoken or felt. These observations were of behaviours, discussions and interactions, all within the setting of the school.

3.4.4.3 Semi-structured interviews

Described as the 'gold standard' for qualitative health research (Silverman, 1998), semi-structured interviews were selected to ensure that similar types of data were collected from individual participants, making analysis easier (Baird, 1999). Semi-structured interviews allow for deviation from a prescribed set of questions, enabling social and personal experiences to be more fully captured (DiCicco-Bloom and Crabtree, 2006), while corroborating previously gathered data, such as documentation and observations, and allowing for issues not already considered to be explored. They also allow for a targeted collection of data from multiple respondents (Jamshed, 2014). Semi-structured interviews were undertaken with each of the children, while separate individual or paired interviews were conducted with their respective parents or carers, to develop insight into the participants' views and to explore themes and issues. In-depth interviews were scheduled in advance and at designated locations, were evenly spaced apart and took into account the child's needs and duration into their placement, in advance and at designated locations (DiCicco-Bloom and Crabtree, 2006).

Interviews with management and trustees

Semi-structured interviews with senior managers and trustees, sometimes referred to as 'elite interviews' (Yin, 2012), yielded rich and extensive data (Hoffmann, 2007). The interview could follow the topics which arose, though this could also lead to the production of seemingly irrelevant data. Although consideration had been given to the issue of power differentials in all the interviews, this was particularly important for the management and trustee interviews. Each interview commenced with my insider-researcher role being named and linked to the fact that those being interviewed were in senior (elite) positions to myself in the organisation, thus creating the potential for a power imbalance (Seidman, 2013).

Gathering these insights was an essential part of understanding the working of the MBS, and although the history and working of the school were already known, this study required a deeper understanding of how the management saw the work being implemented. Interviews were undertaken with the chair of trustees, previously a director of the school, the CEO of the charity and the current director of the school. These individuals do not work directly with the children and so were felt to be more able to discuss the primary case, without being drawn into the detail of individual children.

Interactive methods with children

Regarding data collection with children, it was essential to consider using a range of interactive techniques (Punch, 2002b) as part of a reciprocal dialogue, to support greater involvement from the children, to enable greater depth of understanding and to be less threatening, as the children were already familiar with similar models.

For some children, moving beyond the spoken word would be essential, and so a range of techniques was developed, including visual Stop/Go cards, drawings, objects and photos. Such interactive and participatory approaches are used throughout practice and research when working with children (Punch, 2002b) as a means to develop rapport. Backett-Milburn and McKie (1999) challenge 'draw and write' techniques, claiming that they reinforce a negative view that children are unable/unwilling to communicate and that an expert-adult is required to analyse the child's drawings and writing. This criticism was not felt to be significant to this study, as these methods were used primarily to support the children to feel at ease during the semi-structured interviews, rather than as a data collection method.

3.4.4.4 Focus groups with staff

Focus groups were chosen to complement the other data collection methods and as an efficient way to generate substantial data (Robson, 1997), enabling a combination of both

interview questions and discussion to take place, and providing an opportunity to gain access to participants' views, experiences and attitudes. For this reason, this technique was considered most appropriate for collecting data from staff groups, who were already familiar with this method, empowering them to make comments in their own words, and to be stimulated by comments from other group members (Robson, 1997). This method allowed me to carry out a small number of focus groups, rather than multiple staff interviews. Interview questions were, again, based around themes identified in the literature review.

3.4.4.5 Limitations

Limitations exist for each of the identified data collection methods. Some are specific to the data collection method, but issues to do with researcher objectivity, the potential for bias and the skills of the researcher overarch all the methods identified.

Concerning the archival data, because the data was already held within the school, I did not encounter the usual limitations to gathering the information. However, it was anticipated that conflicting data, representing reports and data collected over a child's lifetime by a significant number of professionals, would be a challenge, though was also viewed as additional data which could be used in developing the 'thick description' (Geertz, 1973) of the case.

Interviews have been criticised for being dependent on participants giving full and helpful answers, which may be impacted by their incomplete recollection (Tellis, 1997). This criticism appears to be based on a search for truth rather than meaning, and the semi-structured interviews in this study were intended to develop meaning, including understanding the differences in recollection and exploring previously unconsidered issues. As with other interview methods, the quality of data collected is dependent on the skill of the interviewer (Powney and Watts, 1987). Thus, I needed to be aware of my own biases and assumptions and the risk of imposing these on the participants. This method does carry the potential for a power imbalance (Powney and Watts, 1987) and an increased risk that

participants will give what they perceive to be the 'right' answer (Brenner, 1981) – something I attempted to alleviate by taking a reflexive stance, developing a relationship with the participants and acknowledging this position from the outset. This bias was further counteracted by using multiple sources of evidence to create a more balanced picture (Robson, 1997).

Some authors (Barbour, 2008) maintain that focus groups can lose their narrative and do not elicit individuals' narratives, though this view is challenged by some (Côté-Arsenault and Morrison-Beedy, 1999), who suggest that a small group size alleviates some of this difficulty, though this would also require the number of questions to be reduced. However, following up answers with individual members is much harder, group dynamics or power issues are more likely to be prevalent, and the group discussion can create 'noise', meaning that the stories may not develop sequentially, making it hard to order and analyse the data gathered (Barbour, 2008). In this study, it was intended that the focus groups would provide complementary data, and so these were not deemed significant limitations. My skills in facilitating groups were essential to ensure all members felt they had a voice and could share their views. By being clear about the remit, the impact of these limitations was felt to have been reduced. These limitations were also ameliorated by the use of multiple methods of data collection, enabling triangulation and converging lines of enquiry, as highlighted by Yin (2014), to ensure the robustness of the case study.

Having outlined the methods used and their benefits and limitations, I now provide an overview of the research process and how the research was undertaken.

3.5 The research process

3.5.1 Pilot study

A pilot study was undertaken with one child as an embedded unit, to help refine the data

collection for both content and procedures (Yin, 2003). This took place over a period of two months and identified a number of key areas for development. The background information sheets raised a number of questions with participants and subsequently required updating. Similarly, the data instruments required refining to make them more accessible.

The data collection process highlighted that the language used for interviews with the children was not appropriate, being too formal and hard for the child to engage with. More significantly, the length of the interviews needed to be shortened. This raised researcher anxiety about whether sufficient data would be gathered – needless anxiety, as a large quantity of data was subsequently gathered!

The initial transcription of the pilot interviews proved cumbersome, time-consuming and inaccurate, making coding difficult and leading to a revision of the research timescale and the coded themes for the main study; the revised list of codes can be seen in appendix 6.

3.5.2 Main research phase

Further learning came from the transcribing and initial coding of the pilot interviews, which took significantly longer than planned and which proved inaccurate, leading to the research timescale being redrafted. The pilot study also suggested the need to organise the interview structure into themes, as shown in table 4.

	Theme 1	Theme 2	Theme 3
Child	History – when you arrived	Here and now	Looking ahead
Family	What happened before the MBS and now	What is happening now and looking to the future	
Staff members	Getting to know the child	Progress	
Senior managers/trustees	How do you understand the work of the school?		

Table 4: Interview themes

Due to attrition, one of the reserve cases needed to be used. Despite initial feelings of frustration, this meant that an additional, unplanned pilot stage had been undertaken and this enabled a further review of the data collection instruments, while all records relating to the withdrawn participant were destroyed.

The codes were defined as phrases which connected to the original research question and which would reflect the meaning of the words and phrases identified (Yin, 2014). I was aware of having to ensure the codes matched the data, and not my presupposed ideas of what the data might be. At times I was aware of my own bias, overcome in part by returning to the codes at a later date and doing a sample recode. The initial quantity of data generated was greater than anticipated and led to changes to the case study database.

The study of each embedded unit commenced with a detailed analysis of written documents held by the school relating to that child, including both internal documents and external professional reports. This was followed by interviews with the children and their parents, and focus groups with the staff team.

In addition to noting the inconsistencies in the data relating to each child, I maintained brief notes about my responses, judgements and potential biases for each one. These were put to one side, to become objective and to recognise my own researcher bias.

The revised timeframe for undertaking the interviews (see appendix 4) was mostly adhered to. However, interviews with two of the children were delayed due to resistance from the children. The number of data collection points for each child is shown in table 5. These are in addition to the document analysis for each child and three interviews with senior managers and trustees.

Child	Interviews with children	Interviews with parents	Staff focus groups
Leo	2	2	2
Lola	3	2	2
Jamie	3	2	2
Kerry	2	2	2

Table 5: Number of data collection points

A more detailed description of the research process is given in appendix 10.

3.5.3 Reflections

On reflection, the interview process for parents and carers could have been undertaken with a more participatory approach, similar to that used with the children. Although the semi-structured interview model appeared to work well, there were multiple times when it was apparent that parents and carers were responding to uncomfortable questions and feelings, and thus the principles of the participatory approach may have enabled them to express themselves more openly and allow for greater depth of evidence collection. The intensity of the interviews and focus groups was not a surprise, but the openness of parents, carers and staff was far greater than anticipated. This led to the parent and carer interview stage of data

collection being more comfortable than expected, and generating more data.

The interviews with the children were more difficult than expected, and, on reflection, more time should have been spent alongside the children before the interviews to develop more of a relationship. Some of the children were wary of me, and although they were aware I worked within the school, none of them knew my role as insider-researcher and seemed ambivalent when I raised it. Although this was an essential consideration in the design of the study, on reflection, it does not appear to have been as prominent a theme as envisaged, and is perhaps linked more to how I viewed my role than to how others did.

The archive and data analysis proved more challenging than anticipated. Although much of the data was already held by the school, bringing it together and sifting through it was a more rigorous and challenging task than I had envisaged, and perhaps one I had been somewhat complacent about given my pre-existing knowledge of the case.

3.6 Data collation and analysis

The first part of the data collation and analysis stage involved working with the documentation relating to the case and to each of the embedded units. Scott's (2006) criteria were used to provide a thorough analysis of the data. Through analysing the archival data and documentary evidence, a new profile of each child was developed. This was transferred to the case study database before the interviews and focus groups commenced.

3.6.1 Recording, transcribing and coding

The recording, transcribing and coding of the interviews was complicated, and I was mindful of the many potential pitfalls, including stereotyping research results, shuffling the data to the

point of procrastination and having problems with closure (Ammon-Gaberson and Piantanida, 1988), as well as more fundamental issues, as described by Easton *et al.* (2000), such as equipment failure, environmental hazards and transcription errors. All interviews and focus groups were digitally recorded, as agreed to by all participants, and wherever possible environmental issues were kept to a minimum.

Although rather arduous, the transcribing and coding stage allowed me to familiarise myself with the data and get a real 'feel' for it through repeated listening and reading. Initially, 'unfocussed' transcription was chosen to represent 'what was said' without a significant focus on 'how' it was said. While transcribing the pilot interviews and starting to transcribe the primary study interviews, I became acutely aware of the time this was taking and the poor quality of my transcriptions. Using an IoE/UCL-endorsed transcription company ensured I had a much faster turnaround for getting the interviews transcribed and that the accuracy was significantly improved, making it easier to code.¹⁹ Although this meant I missed a stage of working with my data, I still read through each transcribed interview several times while listening to the audio recordings, to ensure accuracy and, where required, to make amendments. This stage also enabled me to take note of emotional responses – for example, a parent becoming upset or a child raising their voice.

Prior to coding, it was recognised that coding alone might not allow for all the subtleties of the interviews and focus groups to be recorded, such as non-verbal communication and inference. However, this was overcome by using other sources of evidence, in particular notes, observations and specific notes made when listening to the interviews.

¹⁹ This required an additional process of confirming the confidentiality of each recording and transcription with the company, who deleted all recordings once the transcriptions were complete.

To make the data manageable, the transcripts were coded using NVivo²⁰ software. This allowed for thematic coding of data based on codes selected prior to and during the coding process, and increased the organisation of the data and allowed for quick manipulation of the data, such as searching and the generation of visual connections (Braun and Clarke, 2013). Coding was a recursive process, with codes being revised, added to and amalgamated throughout the process. Software enables coding to be comprehensive, which can lead to increased rigour in coding and analysis. However, several limitations have also been identified with the use of computer packages. Many are related to the user's technical ability to use the software (Braun and Clarke, 2013), and also over-reliance upon the software, rather than using it as a tool to 'aid' interpretation and theorising (Braun and Clarke 2013). Although I had undertaken specific NVivo training and was confident with it, a more significant concern was its potential to distract from the analysis. Bong (2000) refers to this as 'fear-induced analytic avoidance' (procrastination!).

Initial a priori codes were identified through phrases relating to the research questions, and expounded upon during the first set of interviews to give further empirical post-priori codes. Additional codes arose directly from reading the data, representing an inductive approach to the analysis (Braun and Clarke, 2013), as well as through the processes of reflection and of writing notes during the fieldwork process. Once a full set of codes was developed (see appendix 6), the interviews were coded. These were subsequently self-moderated periodically by reanalysing the interviews and identifying whether the data was interpreted and coded differently. Although this was helpful, it would have been more beneficial to have a sample of coding moderated by a different person, or to have had a peer group of

²⁰ NVivo is a standardised computer package used for coding and organising data.

moderators. A final collation of the data was undertaken once all the interviews had been completed, transcribed and coded and the case study database updated.²¹

The informal observations and interviews were coded in a similar way to the semi-structured interviews and focus groups, with attention given to factual and emotional detail. Several additional codes were required at this stage, before the remaining data, documentation and notes were coded. This gave a large number of codes, which was reduced through recoding and pulling the data and codes into themes. These were then put into a data display using a blend of chronology and a flowchart model to co-ordinate the themes. This took several attempts to produce.

3.6.2 Analytic framework

The collated data required more than a thematic analysis, due to the emphasis on participants describing their experiences and the need to look in greater depth. A phenomenological approach was adopted, rather than a definite 'cookbook of instructions' (Keen, 1975), but it also drew on psychosocial methods as a secondary and complementary framework. These were chosen to complement one another and to offer a suitable explorative research design that would prevent or restrict my own biases (Groenewald, 2004).

Phenomenological analysis

The aim of phenomenological research is to provide an accurate description of the research phenomenon, avoiding pre-given frameworks. Phenomenology can be understood as 'trying to understand social and psychological phenomena from the perspectives of people

²¹ The recordings and transcripts are held by me and were not available to others. As per the initial consent documents, these will be retained by myself for a period of three years after publication and will then be destroyed.

involved' (Welman and Kruger, 1999, p.189), or as relating to the lived experiences of people (Greene, 1997), making it particularly appropriate to this study. Guest *et al.* (2012, p.13) expand on this, describing phenomenology as going beyond 'experience': 'the participants' perceptions, feelings, and lived experiences (...) are paramount and (...) are the object of study'. The idea of phenomenology captures rich descriptions of phenomena and their settings (Bentz and Shapiro, 1998), making it an excellent match to the case study's aim to develop 'thick descriptions' (Geertz, 1973). By regarding the term 'phenomenological' as a process with an emphasis on the research participants, greater awareness could be given to the participants' personal experiences, again supporting case study approach.

Psychosocial analysis

Psychosocial methods in research are becoming ever more popular (Hollway and Jefferson, 2011). They generally draw on psychodynamic/psychoanalytic theories of the mind (Frosh and Baraitser, 2008), while adding to the phenomenological approach previously outlined. The psychosocial approach has strong links with a number of fields of practice, many of which relate to this study, including psychotherapy, counselling and group relations. As such, it is a thread linking ideas such as Bowlby's attachment theory, Bion's ideas about group functioning, Winnicott's ideas of holding and containment and the psychoanalytic understanding of the unconscious. At its core is the recognition that psychological issues and subjective experiences cannot be viewed separately from societal, historical or cultural issues (The Association for Psychosocial Studies, 2020).

While the use of phenomenological research pays close attention to the subjective experiences of others – in this case, the children, their families and staff – insufficient attention is paid to what the researcher brings to the case. A more psychosocial approach pays greater attention to the reflexive stance of the researcher, allowing for an exploration of transference and counter-transference, which are core psychodynamic concepts (Hollway

and Jefferson, 2011). This approach allows the counter-transference (the practitioner's response to the transference) to inform the reflexivity of the psychosocial researcher (Jervis, 2009), thus giving greater insight. This model of recognising the unconscious and emotional responses underpins psychosocial research, with Hollway and Jefferson (2011) developing influential research models based on psychoanalytic training, as a way to specifically make sense of the anxiously defended participants. Psychosocial research takes the stance that our 'inner' and 'outer' worlds are inseparable. Although not purely psychosocial, the psychodynamic theory base of this study is similar in many aspects. Both draw on the concepts of splitting and projection, discussed in chapter two, and focus on the unconscious processes participants use for emotional defence.

Other authors (Williams and Cummins, 2018) recognise that semi-structured interviews produce important data which can implicitly communicate unconscious thoughts and feelings. This model avoids identifying one single truth, but returns us to the work of Geertz (1973) and the necessary construction of 'thick description' to create an unconsciously informed case study. Holmes (2013) makes an important observation that reflexivity and the use of the unconscious, particularly counter-transference, are similar features and mutually informative of the research, thus reinforcing Kvale's (1999) concept of the 'novel dataset'.

Having outlined the approaches to the analysis, this chapter now turns to the more detailed process of data analysis.

3.6.2.1 5 steps

When studying phenomena, Hycner (1999) highlighted a crucial point in using phenomenology to look at data, noting the need to avoid 'data analysis', which by definition requires breaking the data into parts, rather than looking at the whole phenomenon. Instead, Hycner (1999) proposed investigating the constituents of a phenomenon while maintaining

the context, which he referred to as 'explicitation'. Given this study's focus on exploring the whole phenomenon, a model of explicitation has been utilised to transform the data through interpretation. The explicitation process employed was built around the five phases identified by Hycner (1985):

- 1) Bracketing and phenomenological reduction
- 2) Delineating units of meaning
- 3) Clustering the units of meaning to form themes
- 4) Summarising each interview, validating it and, where necessary, modifying it
- 5) Extracting general and unique themes from all the interviews and generating a summary

This process proved complex; the model is primarily used for interview data, but for this study was widened to include all sources of data.

Bracketing and phenomenological reduction

The word 'bracketing' refers to 'putting to one side the researcher's biases, personal views and preconceptions' (Miller and Crabtree, 1992). This was of particular importance given my dual role as researcher and employee of the MBS. The word 'reduction' refers to my being deliberately open to the phenomenon in its own right (Hycner, 1999).

Delineating units of meaning

This was perhaps the most critical and time-consuming phase of the explicitation of the data. Critical phrases/words/statements relating to the research questions were isolated from the transcripts and other data sources through coding using NVivo. I aimed to code with no 'overt theoretical steer' in mind (Braun and Clarke, 2013, p.207), which again required a high level of bracketing of personal biases/preconceptions. This process was repeated several

times until I was satisfied that the data had been coded in a helpful and non-biased manner. For some lengthy interviews, this process was repeated in conjunction with the audio recordings and transcripts, to ensure that the subtleties of the data were captured. The delineated units were subsequently reviewed and reworded as 'significant statements and phrases', to make note of the frequency of use, the literal content and non-verbal and paralinguistic cues.

Clustering the units of meaning to form themes

Having reduced the data to the significant statements and phrases (delineated units), these were examined to elicit, firstly, a reduced number of formulated meanings, and then theme clusters and emergent themes. This required a degree of what Colaizzi (1978) named 'artistic judgement': the 'phenomenological researcher [is] engaged in something which cannot be precisely delineated, for here he is involved in that ineffable thing known as creative insight' (as cited in Hycner, 1999, p.150–151). These emergent themes were delineated further to identify principal themes (see figure 3).

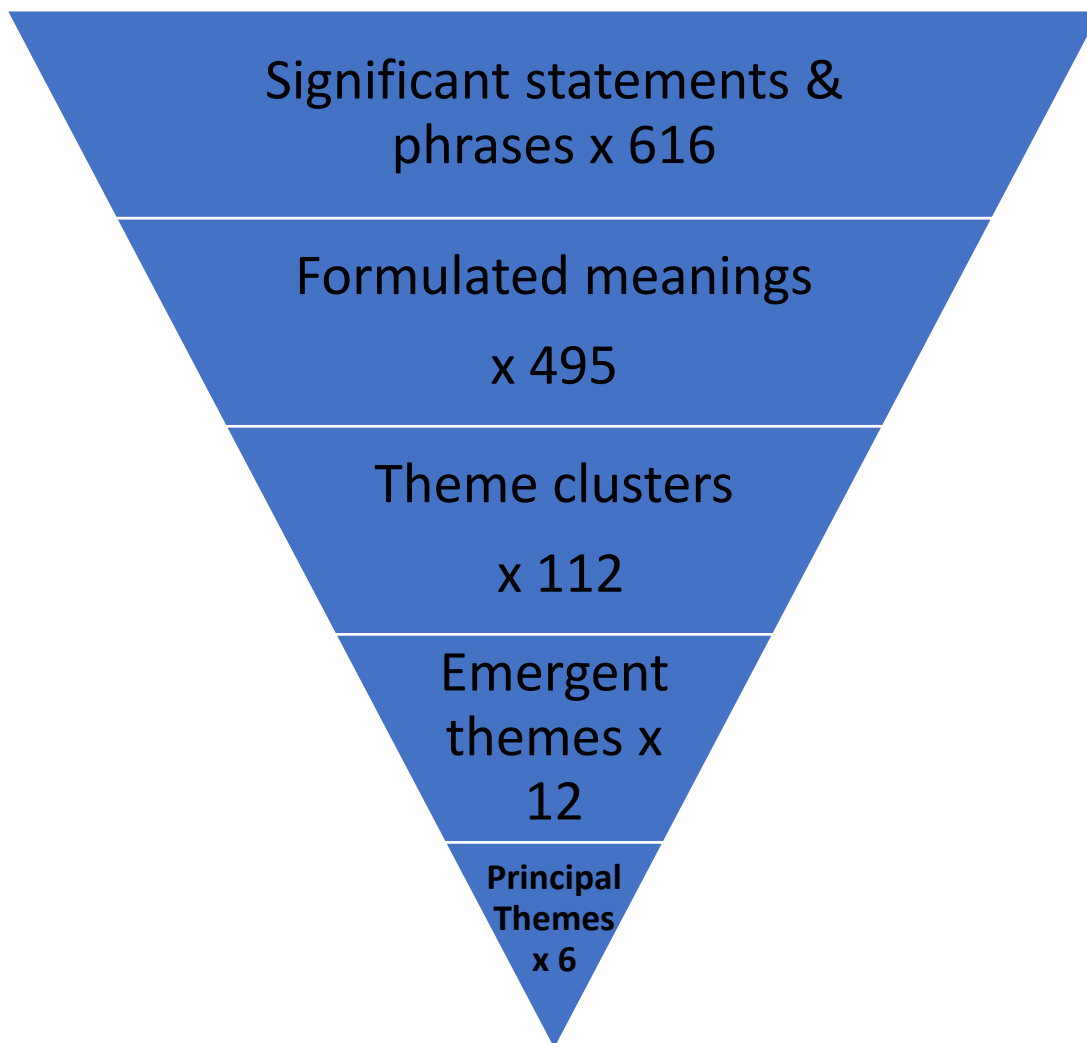


Figure 3 : Breakdown of data into principle themes

Summarising, validating and modifying

At this point, each case was summarised from all the available themes to give a holistic context. I opted not to validate the data with the participants, despite this being standard practice in qualitative research (Hycner, 1999). This was a conscious decision to gather the perceptions and experiences of the participants at a point in time and to recognise the sensitivity of the subject matter. Asking participants to return to these perceptions and experiences might change the free-flowing nature of the discussion and reading what had been said might be emotionally challenging to some. Instead, the validation came from reviewing the original data sources.

Extracting general and unique themes

Once the above steps had been undertaken for each data source, the themes were reviewed concerning each embedded unit, as well as individual variations (Hycner, 1999). Care was taken not to link themes together where significant differences were apparent, before a composite summary was developed for each embedded unit which reflected the themes. This process was repeated for each of the four embedded units before cross-case analysis could take place. In Appendix 11 I detail how my analytical approach operated in practice, taking the example of the theme 'Group Work'.

3.6.3 Cross-case analysis of the embedded units

The analysis of the collected evidence again highlighted the ethical issues running throughout this study. This analysis stage consisted of organising, examining, categorising, tabulating, testing and recombining all the sources of evidence. However, this needed to be done in a manner mindful of the potential risks to participants, yet honest and transparent about the data. This meant highlighting the differences and similarities, while drawing attention to that which may or may not confirm my views as the researcher (Alderson and Morrow, 2011; Winter, 2009). As previously highlighted, my influences and bias were acknowledged, as they were felt to be a particular risk during the analysis stage of the study, which required mitigating.

Due to the subjective nature of qualitative research and the wish to yield rich data, data collection and analysis methods often come under criticism (Easton *et al.*, 2000). Thus, great care was given to identify and follow a robust model of analysis which would recognise that case study analysis can explore a phenomenon holistically, and that the richer and more complete the data, the stronger the case study will be. Despite the development of

converging lines of enquiry (Yin, 2014), the data analysis stage of the case study approach is one of the least developed aspects, and analysis of case data is often hindered by poorly defined analytical techniques (Yin, 2014). To overcome this issue, Yin (2014) proposed several analytical strategies: thinking about rival explanations, relying on theoretical propositions and developing case descriptions. I chose to build case descriptions, starting with a background profile for each child. This 'framework for description' (Yin, 2014) was helpful to have in mind before developing the research instruments, and this was reflected through their design. The descriptive approach is helpful for identifying themes and links for further analysis (Candappa, 2016), and these were developed as I gathered and managed the data, reflecting Robson's (1997) 'flexible design'.

The data was presented in a number of different ways, including mind maps, Post-its and relational charts. Many of these were refined throughout the analysis process – in particular, relational charts linking different data components. Using different methods helped to make the narrative data more manageable and accessible (Miles and Huberman, 1994). One of the most difficult aspects, writing the data analysis, was an important part of reviewing and thinking about the data, finding alternate interpretations and links (Coffey and Atkinson, 1996). The initial draft of each embedded case allowed me to identify themes more clearly, to spot connections between them and to draw out significant themes to compare and contrast before entering them into the case study database, though this also raised questions and inconsistencies.

3.6.4 Analysis of the primary case

The first phase of analysis of the primary case was undertaken separately from the analysis of the embedded units. The initial stage of analysis had taken during the literature review and was developed further using Scott's (2006) analysis criteria. These criteria, and a rigorous model of internal criticism (Tompkins *et al.*, 2009), were used to analyse the

archival data and documentary source material. The internal criticism model was selected, rather than using a sampling strategy during this stage, to create the fullest picture possible, and the volume of data was felt to be manageable.

From this analysis, data was entered into the case study database, thus allowing the data to be themed. Notes were kept of data duplication, and considerable data was set aside due to repetition. Once themes were identified, these were analysed using psychodynamic theory and reflective practice. Due to working in the field of unconscious processes, these explanations were based on theoretical and reflective interpretation, and as such cannot be taken as definitive.

3.7 Ethics

Since the mid-1990s (Flewitt, 2005), a culture that is more inclusive of children in the research process has been developed within social research. This is exemplified by the ethos of organisations such as the European Early Childhood Education Research Association (EECERA). From the outset of this study, the ethical implications were considered, including whether the impact of the study on vulnerable children and their families would be too high compared to the benefits.

The dearth of research relating to therapeutic childcare has already been highlighted. Thus, this study intends to provide research to support the understanding and development of models of practice across the childcare sector, with emphasis on the most vulnerable children. This should lead to improved practice, with positive outcomes for future children and their families. However, a potential ethical issue arose: should the research fail to inform and develop practice, would the impact on the children have been justified? Thankfully, this issue did not arise: a number of areas for practice development were identified and are discussed in chapter seven.

The research requires an understanding and exploration of the viewpoints of all the participants in a manner that is not detrimental to their welfare, either at the time of the study or afterwards. It is also important to promote among participants the sense that they are respected in their own right and are not merely 'objects' for the use of research and researchers. Qualitative researchers such as Alderson and Morrow (2011) have discussed the moral imperative for children's knowledge to be generated with equality, respect and insight, while other authors, such as Carroll (2002), have encouraged researchers and practitioners to develop child-centred methods of data generation. Both these factors were carefully considered when selecting an appropriate methodology, the ethics of which are discussed in appendix 9.

The ethical dimensions of designing and undertaking a study involving vulnerable children and their families were significant, complicated and posed several challenges, many of which reflected the contemporary interest in researching children's experiences and perspectives (Greene and Hogan, 2005). These included issues of participant risk, consent, confidentiality and my role as an insider-researcher, which were discussed in detail as part of the IOE's ethics review process. I received formal ethics approval in the summer of 2014, prior to the data collection phase. These issues are summarised below.

3.7.1 Participant risk

The potential risks to participants included issues of embarrassment, feelings of intrusion of privacy or coercion, fear of admitting anxiety, the risk of feeling coerced into participating (Alderson and Morrow, 2011) and the impact of discussing potentially traumatic histories. To ameliorate some of these risks, formal and informal opportunities for participants to decline participation were incorporated throughout the study (Mason, 2004), and children and families were made aware that the decision to participate or not was not linked to the

children's placements, and what they said would not be fed back or impact upon their placement. This was particularly important when interviewing the parents and carers.

Before discussing the research with any child or family, a discussion was held with school managers to ensure there was no awareness of any particular risk. Children were supported at the start of the research to recognise these risks and to help them make an informed risk-benefit assessment. The staff teams were briefed to offer support where required, particularly prior to and following the interviews.

3.7.2 *Consent*

Consent was considered from the perspective of all participants. Consent was gained by having participants 'opt in' to the study, as a means to develop respect and to encourage their free choice (Alderson, 2004). Consent was clarified as lasting throughout the data collection period, but participants were reminded of the consent process, and shown their consent form, at the start of each interview.

Using the National Children's Bureau (NCB) guidelines for research with children and young people (Shaw *et al.*, 2011) as a basis, a checklist was developed to document what each child should be informed of when requesting informed consent. Overall consent for the case was given by the MBS director and CEO, rather than every member of staff, though they were informed about the study. For the study, I adopted the view that all children within the school were capable of understanding and giving informed consent, as advocated by Flewitt (2005) and Alderson and Morrow (2011). Consent for the children's involvement, as embedded units, was obtained via parents, fosters carers and the children themselves. Where children were under the care of the local authority, additional consent was obtained from social workers. Separate information sheets were developed for staff, parents and children, outlining the aims and purpose of the research, as well as what their involvement would entail and their right to withdraw from the study at any point in time (see appendix 2).

3.7.3 Confidentiality

Throughout the study, it was necessary to recognise that the children were competent to give consent, and that they should expect the same implied confidentiality as an adult (Mason, 2004). Each interview reasserted that the information would be held confidentially, password protected and not shared with others. This was of particular importance when interviewing parents and carers and for reassuring the children that their comments would not be fed back, with the caveat that, where concerns about a child's welfare arose, I had a professional and legal duty to pass on these concerns; however, this never occurred.

Each participant was made aware that they could be directly quoted in the final thesis and that details of their lives would be included, under a pseudonym. Given the small sample and the use of the school's name, it was explained that children and staff would likely be able to identify themselves, but that details would be anonymised as much as possible to prevent external readers identifying children or families.

3.7.4 Insider-researcher

As already highlighted, this research was undertaken while I was employed within the MBS and thus it must be considered 'insider research'. This offered a number of advantages, such as access to the school, defining my role to the participants, accessing internal data and obtaining the support of colleagues (Unluer, 2012), but I also had to address certain disadvantages as a researcher.

Key disadvantages included the potential to overlook children's behaviours and responses as regular, when in fact they should be viewed as extreme, and my closeness becoming a barrier to seeing the bigger picture while collecting data. In addition, consideration was given to my role and the potential difficulties with separating research from practice. Several steps

were taken to ameliorate this issue during the research collection process – for example, using interview locations chosen by the children and families, and not within my general working area. Throughout the process, I was aware that the children and families might also see me in a specific role – perhaps as a manager, an expert or someone with influence over their placement at the school. As highlighted by Finlay and Gough (2003), these power differentials between researcher and participants cannot be ignored.

A significant issue was my relationship with the staff, as I am also a colleague and member of senior management within the MBS. At the start of each interview, this dynamic was acknowledged and put to one side. Again, the participants were reminded of their rights to confidentiality and to withdraw from the interview.

During the transcription and analysis of the children's interviews, attention was given to not 'speaking in their place' and not allowing my background and identity to shape what was said (Alcoff, 1991). This could also apply to the staff interviews, and I had to be mindful not to assume that I knew their views, and also be mindful that the staff might make the same assumption of me: that I already knew what they knew (Unluer, 2012).

It was important to develop a preventative approach to overcome some of the inherent disadvantages of insider research. This included maintaining a reflective research journal as an audit tool, using multiple sources of data, checking interpretations with the participants and gathering feedback from external tutors. It is impossible to state that all bias was removed, but its impact was addressed throughout the data collection and research.

3.7.5 Reflexivity and the unconscious

The application of reflexivity in qualitative research is considered to be an indicator of quality (Frosh and Baraitser, 2008). The dynamic quality of data analysis encourages the

researcher to take a reflexive stance (Braun and Clarke, 2013). Kvale (1999) highlights that, if researchers follow the principles of therapists, recognising their feelings as part of a therapeutic process, then a novel data set can be accessed. Although not employed as a therapist, I work within therapeutic principles within a therapeutic organisation, and thus have recorded and used my emotional responses as part of the data analysis to support understanding and maximise transparency (Onions, 2017a) (see section 3.6.2 on the use of reflexivity within a psychosocial framework).

Within my work setting, emotional responses to interactions with children and families are openly reflected on with colleagues to process and make sense of them. As a researcher, I did not have this opportunity, though in hindsight it may have been useful to develop a research peer group within which to discuss and process these interactions, though of course this would have raised further ethical considerations. As part of the research, I kept process notes and a reflective diary of my emotional responses both to interactions and interviews and when transcribing and coding data.

An important aspect of the MBS's work is recognising the staff's subjectivity; this aligns with the researcher's subjectivity being an important research tool (Crociani-Windland, 2018). These notes were essential for developing the backgrounds of the embedded units, even though they often raised painful and distressing comments.

For a more detailed exploration of these and further ethical issues, see appendix 9.

3.8 Summary

In this chapter, I have described the methodology and process adopted for my qualitative case study of the MBS. In designing the methodology, I utilised a variety of data collection approaches to enhance the rigour and validity of the data collected and analysed.

This study primarily drew upon a phenomenological case study, using a total of 31 in-depth, semi-structured interviews, focus groups and archival data and documentation, as well as informal observations, all of which were analysed using a five-stage model (Groenewald, 2004).

In the following chapters, the school (the case) and the participating children (embedded units) are profiled, before the data analysis and findings are presented.

Chapter Four: The Mulberry Bush School and its pupils

4.1 Introduction

Having introduced the topic and reviewed the literature, this chapter provides a context for the MBS,²² presenting its structures and models of working. This is followed by in-depth profiles of the four pupils, the embedded cases, who sit at the heart of the study. These detail the life events which have led to the children being placed at the school, allowing the reader an insight into the lives of the children and the work of the school in order to develop an understanding of the MBS and its therapeutic approach. Although some of these insights reflect a moment in time, they capture the experience of the MBS, allowing the reader to develop, as much as possible, a feel for the work of the school.

The MBS is situated in the rural village of Standlake, West Oxfordshire, five miles from the nearest town. Standlake contrasts with the socio-demographic areas from which many of the children come. Over 98.5% of the Standlake population is white British, and almost 90% are Christian or have no religious persuasion. It has a higher than average employment level (Office for National Statistics, 2011), with a significantly higher level of professional managers, directors and senior officials. The number of homeowners is also considerably higher than the national average (Office for National Statistics, 2011), and these levels of affluence place Standlake in the top 10% of England. Walking through the village, it is striking how quiet it is; there is one small shop, almost no buses and people walk their dogs down the country lanes.

The school itself is tucked away down one of these country lanes, which has fields, trees and bushes lining both sides. The entrance is formed by wooden gates with an intercom-linked reception. Despite their 70-year history, the buildings are of a modern brick design,

²² This chapter deliberately provides an overview of the school and not the wider Mulberry Bush charity as the study is situated within the school.

since almost all have been built or rebuilt since the mid-1990s. There is a sense of space as you enter the site; at the centre of the tarmacked car park, surrounded by well-cultivated vegetation, sits a six-foot-tall, rusted metal tree which has the names of children and staff inscribed on its copper leaves. Entering the reception area, you are struck by a sense of calm, often highlighted by visitors, and there is a series of plaques on the wall indicating the Outstanding (OFSTED, 2019) nature of the work and of the value the school places on having high standards.

A walk around the school reveals a carefully designed layout, with four two-storey brick residential houses looking out onto a small 'village green', with play equipment, a climbing pyramid, a zip wire, a fenced-off sports pitch and a series of heavy-duty picnic benches. Everything looks clean and well kept, in contrast to some children's homes. At the end of the field is a high wooden fence, behind which sits the new children's home: a large, two-storey building, far bigger than is needed for the six children who may reside there during any holiday period. Visitors are often surprised that the school works with only 30 children, despite the size of the site, which is almost twice, if not three times, the size of the local primary school. That school caters for 150 children, though of course it is not residential and only provides education.

As a researcher walking around the site, it is striking how many staff there are;²³ each child appears to be accompanied by a member of staff. On a school day, the children are all dressed smartly in their school sweatshirts, giving the impression of a regular primary school. As you walk around, it is easy to forget that this is anything other than an ordinary primary school. Young children run around playing, walk to their lessons holding hands with adults and greet visitors with a curious, 'Hello, who are you?' You are also struck by how well maintained the environment is – everything looks new. Staff comment that the frequent

²³ Although the charity employs around 100 staff, many work shifts, and there are normally around 20 staff working with the children at any given time.

damage is quickly repaired to try and break the cycle of destruction, lest it be seen as the norm and lead to further damage.

4.2 The structure of the school

The school is made up of three primary internal departments: Education, Group Living and the Therapies and Networks Team (T&NT). Regarding management and governance, considerable work is undertaken to ensure effective working relationships between these teams. Staff focus groups regularly highlight tensions between teams and departments. However, as I will discuss, staff comments suggest that children's unconscious projections lead to splits within the staff group. These three teams are closely linked through the staff training programme, designed to ensure a shared understanding and approach across the school. The development of a culture of reflective practice affords all members of staff an opportunity to recognise and discuss the emotional impact of the work, and this is discussed in chapter six.

4.2.1 Education

Walking past the glass-panelled dining area, you come to a large wooden sign welcoming you into the school's Education Area. Going through the doors, you immediately notice that the walls are filled with large images of children dressed in outdoor clothing and making fires. Other walls are adorned with children's artwork and large canvas prints of some of the children. This area has soft, colourful rubber flooring, a roof covering and billowing fabric clouds decorating the ceiling. There is a sense of openness and light throughout.

Four purpose-built, ground-floor classrooms are situated around a shared area called Shifford, named after the lane on which the school is located. Each classroom is named after

local rivers, with a colourful wooden sign hanging just outside each door. The doors contain round glass windows, allowing the children inside to see out, and also to enable support staff to look in and identify whether additional support may be required. Each class has two teaching rooms, a small kitchen area and toilets with brightly coloured wall displays, many protected by sheets of Perspex to prevent damage.

Each of the classes caters for between six and eight children and is staffed by a teacher, two teaching assistants and an international volunteer student worker. New children join the foundation class, Windrush, which is more heavily staffed and whose philosophy is based more on play and group work. Many of the children who join the school have been out of education, both mainstream and special provision, for anything up to a year. As such, their first entry into the MBS classrooms is not about academic learning, but about feeling comfortable in a learning environment, being alongside peers and feeling able to try a piece of work – hence the name ‘foundation’, without which there is nothing to build upon.

Children enter and leave classrooms on a regular basis due to their displays of anger, frustration or distress. Some children run around the central area, swearing at staff and other children. Outside one of the classrooms a boy is being held by two members of staff; he spits and kicks at them, screaming ‘bitch’ at one of the staff members. Within minutes he has calmed and he sits with a staff member, bouncing a ball against the floor and discussing a book he has been reading. Interviews with staff highlight that this is a regular occurrence, with children’s behaviour changing rapidly and unpredictably. Staff are required to use their understanding of the school’s theoretical models and their reflective insight to make sense of the children’s behaviour as a communication of unmet need, and simultaneously to help the children make sense of their, often unconscious, actions.

Outside the classroom area is a large sports hall, almost the size of what you would expect at a larger secondary school. Inside is heavy-duty play equipment, a hammock, swinging

bars and a revolving seat; these are interventions to support the children to self-regulate when they become overwhelmed or anxious. In the hall, in addition to regular sports activities, the children meet for weekly sharing times, similar to a school assembly, to share their work and to hear about the achievements of their peers. These can be challenging spaces, with children finding it hard to hear positive comments about themselves; for many, this is a new experience. Often children resort to difficult behaviour, understood as unconscious communications to staff that the experience is uncomfortable and they desire to be removed. Sitting in the sharing assembly, you are once again struck by the ratio of staff to children: most children sit on the floor alongside an adult, with more adults sitting in rows behind them. Some of the children cuddle up to the staff, and others have their hands held to provide emotional and physical support; a few try to run around the hall, but are quickly stopped by staff.

Beyond the sports hall is an outdoor learning environment. A large wooden cabin sits in woodland, complete with tyre swings, fire pits and a small pond, giving a sense of being far from the towns and cities from which many of the children originate. Here, they learn vital skills without the fear of being in a classroom environment: working together to collect wood, make fires and play in the woods.

The education facilities sit at one end of the school; there is a short walk of around 100 metres to the children's residential houses.

4.2.2 Group living

'Group living' is the name given to the residential provision in the school, referring to the underlying principle that much of the work is about living alongside one another. This work is more varied than the educational tasks, taking in the provision of mealtimes, bedtimes,

leisure activities and 'family' living. This means the work continues throughout the evenings and most weekends, though not during school holidays, when most children return home.²⁴

From the outside, the four houses look large; they each have a different type of brick finish, giving a sense of individuality to the home. Small areas of shrubs and bushes sit at the front of each house, and there are large, colourful wooden signs with the houses' names next to the large wooden front doors, like those outside the classrooms. At the rear, each house has a large garden filled with play equipment; some have tyre swings, others have picnic benches and playhouses.

Inside, each house appears spacious. Wide corridors link the individual bedrooms, some of which are carefully decorated with posters and photos, while others seem bare. The latter gives the impression of a child with few possessions, or perhaps a child who, as one staff member describes, 'feels unworthy of having and keeping possessions'. Each of the seven or eight bedrooms looks over the front field or into the house's back garden, giving a sense of space and being in the countryside. The houses are full of posters and display boards, some offering an institutionalised feel – for example, some highlight which staff are working that day, or on which day the children will have phone calls with their parents and carers. Others are filled with children's artwork, as you'd find in most family homes, though often, as in education, these are framed behind Perspex to prevent damage.

Each house has a large kitchen equipped with basic cooking equipment and heavy-duty furniture; it is striking that, throughout the houses, most of the furniture looks heavy-duty and robust. Each house has carefully designed communal spaces: TV rooms with large sofas, playrooms with bookcases full of children's books – which are noticeable as many of the books are for younger children, reflecting the often limited academic abilities of some of the

²⁴ With agreement from the child's local authority, up to six of the children with no stable home environments are able to stay in the Burrow, the school's new, purpose-built children's home.

children – and large wooden doll's houses surrounded by colourful cushions. There are few ornaments around and some bookcases are screwed to the floor, reflecting the level of wear and tear the environment takes from the children's behaviour.

During the daytime, the houses are tidied and cleaned by housekeepers, who leave them almost clinically tidy – each bed perfectly made up for the night – possibly in contrast to some of the children's home environments or to their emotional sense of themselves. Staff describe the children as experiencing the environment as structured, tidy and cared for. This appears to counteract what Reeves (2001) described as children's often chaotic backgrounds allowing them to feel thought about and cared for and to develop their sense of worth.

Each of the four houses is staffed by 10–14 full- and part-time staff, whose ages range from the late teens to the late fifties. Staff work shifts, often a long weekend day, two afternoons and evenings and a morning. The staff take turns to sleep in, ensuring there is always an adult available in each of the four houses throughout the night. There is an expectation that, during the night, children should be asleep, role-modelled by the staff member sleeping in; there are no awake night staff at the school.

Away from the houses, and situated above the reception area, is a series of offices used by various administrative staff and also the team of therapists and network practitioners.

4.2.3 Therapies and Networks Team (T&NT)

The T&NT consists of seven therapists and network practitioners who undertake individual work with children and their families. Therapists include drama, music and adolescent psychotherapists working with individual and, at times, groups of children. Not all the children see a therapist; the provision is based on the children's ability to make use of the

intervention, and for many living within the therapeutic milieu it is considered the most appropriate intervention for them.

All members of the T&NT are based upstairs, giving a physical distance from the children. A range of therapy rooms exist downstairs; overlooking the field there are music and drama therapy rooms which are large and filled with natural light, while upstairs, almost tucked away, is a much smaller, almost clinically bare psychotherapy room.

Within the T&NT are three network practitioners who provide a vital link between the school and each child's family and professional network. The importance of the relationship between the school and professionals for the success of the placements has already been discussed in chapter two. The child is not seen as holding their difficulties in isolation – the network around the child needs to engage in the work, yet it is not uncommon for the professional network and/or the child's family to work in a dysfunctional manner, as highlighted through some of the staff interviews in this study.

Staff describe how the T&NT, Education and Group Living teams are all closely interlinked. For example, each child at the school has a treatment team consisting of members of each department. These multi-disciplinary, termly meetings are relaxed in structure, but bring together a more comprehensive picture of each child. Many of the children present differently in different areas of the school, or when at home, which is often understood psychodynamically as 'splitting', a form of unconscious defence. These various aspects of the child are brought together by the treatment team, to be thought about and understood. All communications about the child and their family are undertaken through this small team. Thus, a further benefit to the team is the shared sense of holding the anxiety and the hope for each child. For many, the anxiety they live with is projected onto the staff working with them, which, without support and sharing, can become as unbearable for the staff as for the child, as discussed in chapter two. It is clear that the communication between these

departments is not only vital, but can be confusing, tense and at times overwhelming in its volume and intensity.

4.2.4 Governance and management

Despite being based on therapeutic community principles, which traditionally have flattened hierarchies, the MBS has a sophisticated management hierarchy, with multiple levels encompassing a wealth of experience. Almost all members of the senior leadership team have been within the school for at least ten years, half for over 20, meaning that they hold not only a management role, but, as the CEO highlights, the important yet unwritten role of ‘guardians of the history’ of the school. As a charity, the MBS is overseen by a board of trustees, a group of volunteers made up of eight professionals from education, law, safeguarding and therapeutic community backgrounds, including two ex-members of staff from the school. Meeting throughout the year, their role is to monitor, oversee and develop the strategic development of the organisation.

The diagram below (figure 4) shows a simplified model of the school’s internal management and staffing structures, which sit under the trustees.

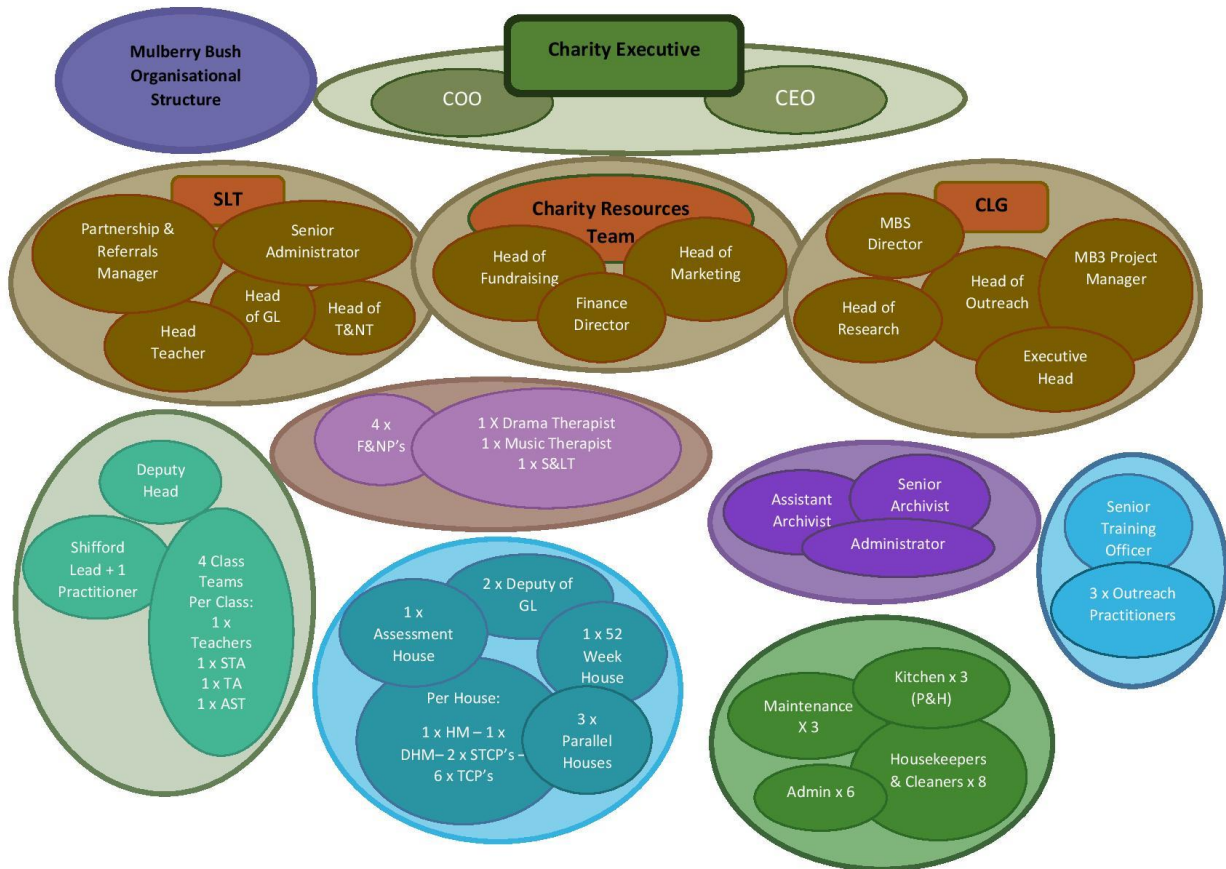


Figure 4: MBS internal management and governance structures

Trustees undertake a range of informal and organised visits throughout the year, ensuring they stay in touch with the school’s work and meet staff and children. Interviewing the chair of trustees highlighted the complex role trustees inhabit, leading termly committee meetings with senior managers as part of the accountability process, but also being a ‘critical friend’, who is both supportive and holds managers to account. The chair of trustees highlights the MBS’s core principle of collaborative working, discussed in chapter two, identifying that the relationship between management and governance is complicated and all the working relationships need to be viewed through a psychodynamic lens. This means the staff team look closely at their interactions and the potential for unconscious conflict, which arises, perhaps, from the projection of anxiety between individuals or departments.

Psychodynamically, this mirrors the experiences of children, who can place parental figures into roles, just as managers are often placed into such roles. Both the chair of trustees and

the CEO acknowledge that this as an essential part of running the school. Both highlight the process which needs to be recognised and continuously worked at to provide management with the ability to contain the strong emotions which arise from working therapeutically with children and families who have experienced trauma. Staff and management interviews reveal times when this level of containment has been lacking, leading to an escalation in children's behaviours because they feel uncontained.

The management team faces a constant struggle to balance the therapeutic needs of the organisation with the dilemmas of being a business – one primarily funded by local authorities. Income is dependent on places being filled, which at times can feel at odds with bringing together an increased number of children, all of whom exhibit high levels of emotional disturbance. The chief operating officer (COO) describes the organisation as 'terribly vulnerable'; there is a feeling that the organisation is constantly 'under threat' of closure due to having to adhere to rigid National Minimum Standards, a stringent inspection regime and the pressures of funding, all of which can combine to give a sense of being risk averse. He describes these issues as creating a 'layer of anxiety' which permeates the school, often reducing the creativity which many of the children and families require.

4.2.5 Staff training

The MBS's commitment to training (Mulberry Bush, 2017a) extends throughout the organisation. All staff participate in experiential learning opportunities, for example training draws heavily on staffs reflective skills to consider the impact of learning on themselves, whilst new staff undertake a two-year Foundation Degree in Therapeutic Work with Children and Young People, at Level 5 in the Framework for Higher Education Qualifications. This is delivered in a collaborative manner, allowing staff from different teams to learn together, helping ensure a consistent understanding and approach across teams. However, the focus of learning is not academic attainment but, as highlighted by Price *et al*

(2018), developing the ability of staff to stay close to the children's feeling states. This involves staff not only learning about psychodynamic theory and reflective practice, but developing the skills to build this into their practice, for example to not just understand transference and projection as terms but recognise when these are occurring and to use this insight to understand the children's needs. The model of training and reflection differs from many settings which focus on behaviour management, instead focussing on working with behaviour as a communication of need.

4.3 Model of practice

Within the three core principles, discussed in chapter one, sits the belief that all children have an inner world or internal emotional life formed from their experiences that impacts their relationships and behaviours (Mulberry Bush, 2017a). Chapter two discussed the individual theories underpinning the work, including psychodynamic theory, attachment theory and systemic thinking. However, the model of practice is more complex, formed by intertwining these theories to develop the therapeutic milieu, described by Price, Herd, Jones and Sampson (2017) as the 'web of relationships' which exists across the school. The children live together as groups, alongside adults who support them throughout each part of the day, providing a 'planned environment' (Harriss, Barlow *et al.*, 2008). As such, there is not a strongly defined prescriptive approach or intervention, but a culture, at the core of which sits the 'use of self', described by Ward and McMahon (1998) as a way for professionals working with troubled children to further develop their intuitive capacity, in order to establish a better and more conscious, reflective 'use of self'.

Staff highlight how much of this reflection involves supporting the children to get in touch with their feelings. Much of this painstaking work is achieved through the staff role-modelling awareness of emotions and talking about emotion. Many of the children cannot describe how they feel as they are unaware and unable to put words to these feelings. Hence, they

respond through impulsive and often body-driven responses. Many of the younger children must learn what is meant by 'sad', 'angry', 'happy', 'excited' and so on. Usually the staff will observe the children and wonder aloud, 'I'm wondering whether you are worried about such and such', or help the children relate bodily sensations to emotions – for example, by recognising when a child's body language becomes tense and wondering whether this indicates that they are feeling stressed. For some children, this may be supported through visual symbols, but for most it is the constant wondering and naming of feelings which, over their three-year placement, enables them to become aware of their feelings and respond to them. One of the children in the study told me how, after two years at the school, he was now finally able to recognise when he was 'going to explode' and to ask staff 'if I can take some space, so I don't hurt anyone'.

Staff are supported to work hard to remain close to both the children's feeling states and their own; a constant process of reflection helps them to recognise and make sense of their feelings as a way to see 'behaviour as communication', to make sense of what is happening across the community. This model of reflection underpins the whole culture of the school and is observed in the interplays between staff, children and families. This is a process which staff describe as essential, difficult and often painful. During staff interviews, there were multiple references to the emotional impact of the direct work with children and families, as well as the range of reflective opportunities built into the model of practice to enable staff to process emotions. For example, in fortnightly reflective spaces, staff spoke of using their psychodynamic framework. They spoke about the children projecting unbearable feelings of distress and rejection onto the staff, as discussed in chapter two, yet how the culture enables staff not to become overwhelmed by this, but to return each day, often to face fresh projections from the children. For most of the staff, this is the first time they have experienced such intense projections of hatred, sadness and anger. Staff describe how hard it can be to recognise which feelings are their own and which are projections. At times, staff become frustrated with aspects of the culture, wanting a much clearer model, 'a written-

down guidebook of what to do', yet they know this is not practical due to the need to work in the moment, or 'reflect-in-action' (Schön, 1987), rather than abide by written instructions.

This model starts when children first join the intake/assessment house (Rainbow House) for their 12-week assessment period. This provides a gentle introduction to life at the school, allowing time to build relationships and to undertake an assessment based on the team's experience of living alongside the child, as well as a range of other assessments – some standardised, some not. This helps the staff develop their understanding of the child's stage of emotional and social development and how to meet their needs. This is written into a treatment plan by the treatment team, which details the work for each child, including how the group-work model will support them.

4.3.1 Group work

The theoretical background to the use of group work is discussed in chapter two, but it is important to outline what this looks like on a day-to-day basis.

All the children participate in a range of formal and informal groups according to their ability. Groups are carefully thought about to provide a physical and emotional sense of safety for the child, a place where they can explore the dynamics of being together. For some, this may be watching TV and eating with another child; for others, it may involve sitting in a daily group, talking about the difficulties of the day and how they have left them feeling. Children's capacity for engaging and coping with these situations can vary day to day, and staff are required to make constant judgements about what the children can tolerate, to challenge and support them simultaneously. This can prove a fine line for many of the children, and it is dependent on staff having good relationships with the children; the strength of these relationships can often hold the child's anxieties, like a mother holds and contains the infant's anxieties.

Informal groups include regular mealtimes and playtimes, where children may have to learn to tolerate sharing a table, waiting for another child, sharing a staff member's attention or playing a turn-taking game. It appears that these spaces can be particularly difficult for the children. Staff reassure them, reinforcing the rules and social expectations which many of the children struggle with. For example, one of the children had never experienced consistent mealtimes, and the idea of sitting in a group at set points of the day to eat and talk appeared to be overwhelming. Many of the children treat the mealtime as functional; they eat and wish to leave immediately, exhibiting behaviours which can make it unsafe for them to stay. Despite the informal nature of the group, staff still observe the dynamics, naming what they think is happening in the group, ensuring the safety of the children and having fun – they are children, after all!

Formal group work takes place in a range of ways across the week, with sessions depending on the skills and abilities of each child. One of the most formal groups takes place weekly and is referred to by staff and children as 'group-work time'. Children are encouraged to be part of a small group: they choose a name, set the rules and, where appropriate, agree various rituals – for example, how someone's leaving is marked. Each group adheres to clear boundaries of time, space and membership. What occurs within the group is maintained separately from outside the group, as with a therapy session. The boundaries create a space in which the children can enact coping strategies, while staff can observe and offer the children an experience, such as containment, which helps them evolve their coping strategies in healthy ways. Staff are encouraged to focus on the process of the group, not just the content. These groups can often be intense, which can stimulate the coping mechanisms of some children and hinder others (Staines, 2017). Each of the formal groups is facilitated by a pair of staff, with a third staff member outside to support children who may need to leave. The groups are set up to be nurturing and often involve food, drink or a game; they last for around 45 minutes and many are weekly, again depending on the ability of the

groups. Each group will have an activity, such as drama or a turn-taking game. Due to the nature of these groups, I was not allowed to sit in and observe, but I watched the children walk to and from the space, shouting and appearing to become anxious. Some shouted, 'I'm not going, you can't make me', or words to that effect.

Other formal groups include daily meetings in each house and class, where children and staff are supported to think about how they are feeling, behaving and the dynamics within the group. These appear to deviate from the model described by Haigh and Pearce (2017), perhaps to better match the needs of primary-aged children. When I joined one of the house meetings after school, the children all sat in the living room with the staff team. One child rolled around on the floor making grunting noises, while another tried to kick him. Staff tried to help the children make sense of this, saying, 'I wonder if you are cross that he disrupted lunchtime?' which led to a group discussion about how lunchtime felt, who had contributed to the difficulties and how things could be resolved. Staff spoke calmly, yet with authority, naming what had happened and questioning how the children felt – importantly, without any sense of persecution – exploring the dynamics within the group. Some children were able to partake in the discussion, while others, including both the previously mentioned children, appeared to show their unease through behaviours. One child made repeated 'whooping' noises, appearing to try and drown out the discussion, while another shouted, 'Shut up, you're just making it longer.' Staff named these behaviours to the group, suggesting that the children were 'finding the discussion difficult' but that it was important. One child ran out of the room, followed by his female keyworker. A male staff member asked the children what they felt about their day, to which one child replied, 'It was shit.' Another indicated that she was pleased to have got a certificate for her classwork. At the end of the meeting, a senior care worker commented how helpful it had been to hear the children share their feelings, thanking those who had remained in the group and giving options for the children's playtime.

As part of the tradition of therapeutic communities, additional groups can be called to discuss and address issues as they arise (Haigh and Pearce, 2017). Within the school, this frequently happens in class and house groups, but less so as a whole school community. One example occurred concerning a high level of aggressive behaviour within the child group. The senior leadership team called all children and staff together in the hall and started by naming some of the events that had happened in the school: a recent visit from an ex-pupil, some dangerous behaviour from a child, a popular member of staff leaving and various people being off sick. It was wondered whether these issues were causing distress for the children, who could not name them, thus requiring the staff to bring them verbally to consciousness, leading to a discussion. Anecdotal evidence for the rest of the week indicated a much more settled child group, and staff group, with reduced levels of aggression and challenging behaviours. Within all the groups, it is noticeable how quickly the children's emotions and behaviour can change. One minute they appear calm and engaged, but they can suddenly erupt in anger and frustration, lashing out with their words and often their hands.

4.4 The children

The MBS children come from all over England, and at the time of writing the school is made up of 79% white British children, with over 86% having special education needs²⁵ and 53% being 'looked after children'.²⁶ Of the children, 24% normally reside with a member of their birth family, 57% with foster carers and 19% with adopted families. The children are placed by local authority Social Services and Education departments, having experienced multiple placement breakdowns, both in their families and in school. The children's behaviours are often extreme and can include regular physical attacks on peers, family members and

²⁵ The national average in mainstream schools is 14.6% (Department for Education, 2019).

²⁶ Looked after children are those for whom the local authority has had to legally intervene and take on parental responsibility to ensure the safety and welfare of the child.

professional staff; sexualised behaviours towards staff and other children; and extreme risk-taking behaviours such as roof-climbing. Although not all children are diagnosed with a recognised disorder – for example, attachment – they all struggle with the intensity of relationships, whether in the family or in the classroom, and they exhibit their emotional distress and trauma through their behaviours. Using psychodynamic theory, this may be understood as a defence against trusting others or creating relationships, though of course this is at an unconscious level. Many of the children function emotionally, socially and academically at a level far below their chronological age. These characteristics can all be seen in the profiles of the four children who participated in this research study.

4.4.1 Leo

Leo is a ten-year-old boy of white ethnicity, who is tall for his age and has a stocky build. His hair is clipped short and gelled back. He likes to dress in casual sports trousers, a football top and trainers, in keeping with the other children from his estate. When not at the MBS, he lives with his birth mother, two of his older siblings (both in their twenties) and the family dog in a three-bedroom terraced property on an inner-city estate, probably constructed in the 1960s, in an ethnically diverse area. The census (Office for National Statistics, 2011) reports that over a quarter of the residents are from ethnic minorities. Despite the local area having decreasing crime figures, there is a recorded increase in violent crime in the area (Council, 2019), something Leo's mother describes as 'worrying', suggesting it is the norm for living on such an estate.

There is little outside the house to distinguish it from the neighbouring ones. Most of the houses are grey and relatively small, with wooden cladding and without front gardens or any visible vegetation. The family home is near to local shops and main roads, giving the area a busy and noisy feel, contrasting significantly to the quiet, rural setting of the MBS. Other

extended family members live nearby and are frequent visitors to the house, providing support for Leo and his immediate family.

Leo is the fifth and youngest child of his parents, who separated for several years before getting back together and having two further children, including Leo. Although born a couple of weeks early, after a brief labour induced by a sudden family bereavement, Leo was healthy. The first few weeks of Leo's life were understandably hard for the family, though Leo was described as doing well, eating well and developing a good sleep pattern. Although he met most of his early-years milestones, there was a noticeable delay in the development of his fine and gross motor skills, which led to occupational therapy involvement later in his life.

During his early life, his parents frequently argued, and his father left when Leo was two years old. Although his father lived nearby and visited intermittently, Leo's mother described Leo as being disappointed by his father failing to show up when agreed. On these occasions, Leo would become extremely unsettled and upset. His mother describes his relationship with his father as far stronger than his siblings' relationship with their father, and directly linked the absence of his father to the development of Leo's anger and aggressive behaviour.

Staff describe Leo as a tactile child who enjoys physical contact, particularly during bath times and nurturing activities. Despite having his own room at home, he insists on sleeping with his mother, staying up until late at night playing on his games consoles and watching TV, often including age-inappropriate films. His mother described him as having a great deal of freedom at home and as having no control over his behaviours, but she was keen to highlight the many positive aspects of their relationship. He is a young boy who loves praise and adult attention and is always eager to show off newly acquired skills, such as the circus skills he learned while at the MBS.

When Leo was seven, a family member was murdered in a high-profile case by another family member, causing understandable distress for the family, particularly Leo. A heavy police and media presence followed Leo's mother, making this a particularly difficult period for him and resulting in an escalation of his challenging behaviours.

Although schools in the local area do well academically, compared to the national average, they have an above-average number of children claiming free school meals, a factor that correlates with low incomes. Up until the age of eight, Leo attended a local mainstream school, where he often struggled with being in a group, becoming loud and talking over others to get his own needs met. Reports described him as easily distracted, fidgety, seemingly unable to sit still for any period and struggling with adult authority. As a result of his increasingly challenging behaviour, he was moved to a local special school. However, this and subsequent placements broke down; schools felt unable to manage his responses, which included physical and verbal aggression, and stubbornness. Aged nine, having been excluded again, he commenced a period of being home educated. However, tutors were often unable to engage him in any academic work, and he would often leave the family home – climbing out of windows if necessary – to meet with older boys in the local area. Although he did commence another educational placement, this lasted only a matter of days before Leo refused to return, citing physical and threatening behaviour from other children.

Attempts at ongoing home education were later stopped because of Leo threatening tutors and preferring to stay at home or wander the local area. On multiple occasions, this led to police involvement, typically for antisocial behaviours such as vandalism, and he was frequently returned home by the police.

When presented with academic work, Leo is described as often feeling challenged, resulting in him becoming visibly agitated, often running out of the room or becoming impulsive and aggressive. His immediate response appears to be 'I can't do this'. His physical aggression

can happen daily and has often required staff to hold and physically restrain him to maintain their own safety and that of other pupils. The use of restraint often escalated his aggressive behaviours, leading to several schools regarding him as a highly vulnerable pupil. The level of his behavioural difficulties often led to him working individually, with considerable support from two, sometimes three members of staff; subsequently, he felt isolated from his peers and developed limited social skills as a result.

Before the MBS, Leo undertook a range of assessments which identified no evidence of ADHD or ASD, but did find complex learning needs with significant language and communication difficulties, and a cognitive assessment that falls within the moderate learning difficulties range. Further assessment, when he was ten, highlighted a conduct disorder (not a psychiatric disorder), citing evidence that he was often threatening, initiated fights, could be physically cruel to others and had stolen money and destroyed property. Leo's educational statement of special needs highlighted him as having SEBD (Social Emotional Behavioural Difficulties), stating that this was the most significant barrier to him accessing the curriculum and making friends, thus having a considerable impact on his attitude to learning.

Staff at the school describe Leo as a boy who absorbs all the positive experiences presented to him. He is always keen to throw himself into activities and, although homesick, he makes good use of his placement, enjoying the company of the other children and the staff. They describe his family as approachable, supportive of the placement and keen for agencies to support them.

Increasing aggression and placement breakdown are a familiar pattern for the children at the MBS, as highlighted in the interviews with senior managers and the chair of trustees, indicating that Leo's profile is indicative of many of the children placed at the school. There is some lack of clarity about what exactly led to an increase in his aggressive behaviours, and

this may be attributed to gaps in information. However, attachment theory would suggest early-life trauma and pervading levels of aggression as he grew up, leading to his anxiety about creating relationships, which he manages via his behaviour.

4.4.2 *Lola*

Lola spent her early life in a family where drugs, alcohol and domestic violence were common. Looking at Lola, you are immediately struck by how often she smiles. Lola is of average height and build for her age – she was just over seven when she started at the MBS. She dresses smartly in her school uniform, wears glasses and has her long hair carefully plaited with a ribbon. She takes pride in how she looks, allowing grown-ups to help her choose her clothes and plait her hair. She is often seen walking around holding a teddy bear or another soft toy, and when anxious she uses these to communicate. When you speak with her, she presents as a bright, alert and articulate girl, though often she appears shy, speaking in a quiet voice which can conflict with her often abrupt and direct questions. Staff describe her as endearing, affectionate and playful.

Lola was born in a predominantly white socio-economic area (96% white, with 95% born in the UK; ONS, 2011). Employment levels there are similar to the national average, but it is in the top 20% most deprived areas in England. This is reflected in Lola's family background: her mother did not work, her mother's partner moved between low-income jobs and the family often struggled financially. This contrasts with her current foster family home, which, although not geographically distant from her birth area, is situated in a modern-looking cul-de-sac in an affluent neighbourhood. The foster home is comfortably decorated; a sense of family exists, with framed photos on display throughout the home. In front of the home is a well-tended garden, providing a sense of welcome as you approach the house. Nearby is a small park and children often play in the gardens in front of the houses.

Lola was the second of three children, and there was significant involvement from Social Services before her birth, primarily due to concerns about her parents' considerable drink and drug issues, as well as depression and regular police and health authority involvement. Concerns had been raised concerning Lola's older sibling, who was at risk of foetal alcohol syndrome, and there were reports of domestic violence and threats between the parents since the older sibling's birth.

Although her father moved out of the family home before Lola's birth, the parental relationship resumed shortly afterwards, resulting in an increased level of arguing in the family home. During the pregnancy, a care plan was instigated by the local authority amid concerns about emotional harm, and there was further police involvement when her father assaulted both Lola's mother and older brother. Initial reports about Lola from health visitors were positive regarding her development and her mother's ability to parent, despite ongoing concerns about alcohol use.

Lola's early months saw her mother experience post-natal depression and there was further concern around her father, who was not permitted sole care of either of the children due to previous cautions for assault and domestic violence. By the time Lola reached her first birthday, further significant concerns were being raised about her mother's ability to care for Lola, with reports that she screamed and swore at the children. In addition, the parental relationship was always tense, with multiple separations and returns to the family home.

The subsequent two years saw ongoing involvement from the local authority concerning child protection concerns for both children. Both parents were drinking heavily, with continuing police involvement and reports of domestic violence, physical abuse and neglect of the children. The mother's subsequent relationships followed the same pattern of aggression, argument and domestic violence. Violence in these relationships was not limited

to the mother; the siblings disclosed suspected sexual abuse, although this was never substantiated.

When Lola was four, the local authority undertook a full core assessment which identified that the family environment was not suitable for the children: there were no toys, no working lights and the house was full of smoke. After this, both children were removed to a fostering placement. Although the local authority made attempts to have the children adopted, no suitable carers could be identified, leaving the children in long-term foster placements.

Despite her difficulties, Lola was placed at a mainstream school close to her foster carers, with considerable additional support funded by the local authority. She had excellent attendance at school, but often found it hard to engage directly in lessons and was statemented in Year 1. Her preferred subjects were PE, art and cooking – subjects her teacher felt caused her less anxiety and fear. While attending this primary school, Lola had weekly music therapy, outdoor learning therapy and daily time away from the regular classroom environment.

Lola was diagnosed with an attachment disorder by a clinical community paediatrician when she was six years old, though she does not appear to have been formally assessed for this. Instead, this diagnosis seems to have been made based on written and verbal reports from a range of professionals and the foster carers. The same paediatrician ruled out a diagnosis of autistic spectrum disorder. Attempts at other forms of assessment – for example, speech and language – were often unsuccessful as she refused to co-operate and became anxious and aggressive. However, it was recognised that she was bright, with no noticeable language difficulties, but that her fundamental problems were with her social interaction, trusting people and developing and sustaining relationships.

At the point of referral to the MBS she was in full-time education, but due to her anxiety and presenting behaviours she was not accessing the curriculum or felt to be making progress; any link to learning resulted in an anxious or angry response. She was considered to be in a permanent state of high arousal, highly anxious and trying to control all relationships, whether with children or staff. She responded to boundaries and discipline with opposition and aggression, lashing out at peers, carers and teachers. She regularly pushed those around her for an angry response and seemed to be recalling her early abusive experiences, while trying to recreate these feelings with her carers. In addition, there had been a history of her displaying sexualised behaviours in previous settings, such as touching herself, but this has not been overtly shown at the MBS.

While her levels of aggression were like the profiles of the other children in this study, there were fewer significant incidents, perhaps due to her younger age and smaller size. In the classroom environment, Lola was felt to be particularly anxious and avoidant of anything challenging, becoming disruptive to avoid the work set. At times she was physically hurt by other children, or through regular childhood falls and accidents, but she appeared to show no sign of pain and was described as being extremely sensitive to noise.

Her Statement of Special Education Needs identified areas of need related to her social, emotional and behavioural development which significantly impede her ability to engage in learning.

4.4.3 Jamie

Jamie was nine years old when he arrived at the MBS. He is of white ethnicity and described by his adoptive parents as Christian. Jamie lives in an area with one of the lowest populations of white British people in England, and a high population of individuals recorded as Muslim. Jamie is tall for his age and of average build, with a mop of dark hair and

glasses. Like other children at the school, he appears to be aware of his appearance; when not in his school clothes, he dresses in jeans, trainers and T-shirts – smart, casual and typical of his age group.

At the time of writing, Jamie lives with his adoptive parents and their older adopted daughter in a populated urban area. The family home is of modern design, terraced, in a small close on a built-up estate. The local area is one of the most ethnically diverse regions in England, with one of the youngest populations, and it is among the 5% most deprived areas in the UK, with high levels of poverty and poor health and low levels of education. Near the home is a large area of grassland where Jamie often plays with other children from the local area. As with many boys of his age, he enjoys playing football when outside, but prefers to stay inside playing electronic games.

Jamie's birth mother was a 'teenage mother', who separated from his father early in her pregnancy. His birth had some complications, resulting in him spending the first two weeks of his life in the Special Care Baby Unit (SCBU). Shortly after he was born, his mother commenced a new relationship with a man known to misuse drugs and who was physically and emotionally abusive towards her and, reportedly, Jamie. This new partner spent periods in a psychiatric setting, and there are unconfirmed reports that he also caused a fatal fire in which Jamie's cousin died.

Jamie's early years were a mixture of neglect, limited stimulation and supervision and a chaotic home environment, with regular concerns being raised about Jamie's welfare. He was left in his high chair for long periods, left in dirty clothes and soiled nappies and inconsistently fed. When he was three, Social Services initiated a Section 47 review because of Jamie's mother's drinking and burns Jamie sustained while in her care. As a result, he was removed from her care by the local authority and placed with his maternal grandmother, who also cared for other grandchildren and his maternal aunt. During this short period, his

challenging behaviours and defiance were noticed, leading him to be moved to other family members. During this period, his mother started another violent relationship and gave birth to twins. Shortly before turning four, Jamie was removed from the care of his extended family, as they were unable to continue supporting him and manage his aggressive behaviours. Subsequently, he was placed with foster carers – his fourth carers before the age of four – who later successfully applied to adopt him. At the point of referral to the MBS, he maintained minimal contact with both his birth mother and birth siblings, which caused him considerable confusion and upset both prior to and after each contact.

By the time Jamie was in Year 2 of primary school, his anxiety, aggressive outbursts and soiling were causing significant concerns, with school and home expressing that they felt unable to keep him, and themselves, safe. Psychotherapy, which his adoptive mother attended, did little to reduce his difficulties; instead, as he became more aware of his emotions, he became more aggressive and controlling, both at home and at school. Both adoptive parents struggled with setting and maintaining boundaries around his behaviour, and were unable to provide consistent discipline for Jamie. Subsequently, both Jamie and his adoptive sister were placed under child protection plans – his sister particularly as a result of the aggressive outbursts she experienced from Jamie.

Before his referral to the MBS, Jamie was involved with the police multiple times, for threatening his family with weapons, causing significant damage and absconding from home and school. His family have reported that they had to lock him in a room when he tried to attack them and wait for the police to arrive. He has been excluded from schools multiple times for aggression towards others and extreme risk-taking behaviour. Previous schools had to contact the police after Jamie became aggressive, and on occasion it has taken several police officers to restrain him.

He was excluded from his most immediate school placement before the MBS following a significant incident where he absconded from school with other children, which involved a major rescue operation by emergency services. The school felt they were no longer able to keep him and other pupils safe, particularly after a consultant psychologist recorded that there was potential for a child to die. After this exclusion, he was home educated for several months while the local authority sought an appropriate placement. During this time, he was increasingly aggressive towards his family, and unwilling or unable to engage with home tutors.

Previous schools have highlighted his academic abilities, describing him as bright and competent, but also highlighting his overwhelming difficulties with relationships. In the classroom, Jamie was an able child who enjoyed maths, had a good imagination and enjoyed typing stories as he disliked writing. It has been noted on many occasions that when staff are off work – for example, with sickness – his challenging behaviours escalate and he becomes more impulsive and aggressive. When introduced to new staff, he is dismissive of them, refuses to engage and is aggressive towards them, making it hard to form a relationship with him. He is a sporty child, happy to try different sports, and he can tolerate not winning all the time.

Throughout his life, Jamie has experienced the involvement of multiple professionals and undertaken a wide range of assessments. He is an intelligent child with lower than average speaking intelligence, possibly linked to a lack of stimulation when living with his birth mother. Shortly before commencing at the MBS, he was diagnosed with profound and complex attachment difficulties, which highlighted his need to dominate and control, as well as his struggles with separation and change. He has also been assessed for both ASD and ADHD, though not diagnosed with either, and professionals concluded that he was still young enough for substantial therapeutic input which could 'significantly improve his developmental potential'. It was thought a long-term placement would best meet his needs,

as he struggled with relationships. A placement which could work with his need for more regulated and predictable behaviour and emotions was sought out, namely the MBS.

Unusually for children who enrol at the MBS, he did not visit beforehand, as it was considered it would be too difficult for him. Instead, Jamie's adoptive parents brought him on the day his placement started.

Staff at the MBS describe Jamie as a boy with a vivid imagination and a good sense of humour. He enjoys his food and is described by his family as being a healthy eater. He has been able to develop some peer relationships, but other children are often wary of him, and it appears that he has no real friendships. MBS staff and Jamie's family all highlight his strong desire to learn more about his past. Interviews with Jamie further supported this.

There is an active link between children who have experienced neglect in their early years, growing up in environments where violence is present and at times accepted, and an increase in aggressive and risk-taking behaviours (Dickson *et al.*, 2010). Given his early-life experiences of lacking a consistent carer, his diagnosis of an attachment disorder can be understood, and his exhibiting behaviours are consistent with this (Ainsworth, 2014).

Although not all children at the MBS are diagnosed with an attachment disorder (Diamond, 2013), the majority of children experience difficulties with forming and maintaining relationships (Harriss, Barlow *et al.*, 2008).

Unlike many children at the MBS, Jamie's placement is funded by Social Services, Education and CAMHS. This perhaps signifies the level of shared concern about him across services.

4.4.4 Kerry

As with the other children in this study, Kerry's early-life experiences before being placed at the MBS involved traumatic events, leading her to develop high levels of anxiety, anger and aggression. These behaviours led to multiple educational placement breakdowns, pushing the family to what her birth mother described as 'breaking point'.

Kerry is of average height and slight build, with shoulder-length hair. She is often seen wearing a muddy sports kit and can appear ambivalent about her physical appearance. She lives with her birth mother, stepfather and three younger siblings, two of whom are half-siblings. The family home is on a large estate in a built-up region north-west of London. Like 45% of her local community, her family describe themselves as white British and Christian. Kerry's mother does not work, reflecting local unemployment levels, which are higher than the national average (Office for National Statistics, 2011); there are also higher than average levels of deprivation and people with no qualifications, and lower than national levels of homeownership (Office for National Statistics, 2011).

The house is in a row of 1960s council-built social housing, backing onto garages; many of the properties are rundown. Aerial images show multiple rows of houses, separated by grass verges and open play areas nearby, though there are few trees or bushes. Members of the extended family live locally, and the family appear close, often visiting and looking after one another.

Kerry's birth father lived with the family until she was two years of age; her parents separated due to ongoing domestic violence. However, her birth father was keen to maintain contact with Kerry, and this continued until it was stopped by Kerry's mother when their daughter returned to her with an unexplained physical injury. This led to court proceedings which granted her father regular contact. Subsequently, her mother developed increasing

concerns about Kerry's escalating levels of aggressive behaviour around the time of these visits.

Kerry has been excluded from several local schools for physical aggression towards children and staff and she was out of school for five months before joining the MBS. Since Year 3 she was considered to have made limited academic progress, despite reports describing her as a bright child. Her behaviours have been described as 'unpredictable, increasingly violent and difficult to manage', resulting in restraint and injuries on multiple occasions. This corresponds to her behaviour at home, where she often targeted siblings and parents with aggression, and on some occasions with weapons. Interestingly, this is in stark contrast to the behaviours she has shown at the MBS, with staff describing her as withdrawn but 'never aggressive'.

From the age of six, the family expressed concern about her aggression and her self-harm, which resulted in several hospital visits. Aged seven, Kerry was referred to a local parent-child mental health assessment centre following a significant incident of self-harm. Kerry described hearing voices which told her to hurt others and she remained at the inpatient unit for almost four months. Several months after leaving this unit, she disclosed that her birth father had sexually abused her. Within six months of leaving, she was referred again due to an escalation in her aggressive behaviour. However, this referral was not taken up by her family due to implications around the care of the other siblings.

Her increasingly challenging behaviours were often described as being sexualised; she attempted to start fires and displayed extreme levels of aggression. The inpatient assessment identified a secure link between her mental health issues and contact with her birth father, against whom Kerry continued to make allegations of physical abuse. This led to police involvement, which Kerry was often reluctant to engage in. Her verbal and physical

attacks on her family led them to request support from the local authority and Kerry was placed on the Child Protection Register.

Before her placement at the MBS, Kerry's family received significant levels of family support in the form of family link works, GP services, mental health services and additional support for Kerry while at school. A considerable amount of individual therapy was provided, which was felt to have had a limited impact as levels of aggression at home continued to increase, leading to further involvement from Social Services, who were unable to identify an appropriate foster care placement for her. The consultant paediatrician reports described her as not having a psychiatric condition, but as having 'dissociative behaviours' of the form of someone who has 'experienced some form of abuse', possibly sexual, given her behaviours. Her mother describes Kerry as an 'insomniac', which led to the family having frequently disturbed sleep and her mother, in particular, feeling in a constant state of exhaustion, until the placement at the MBS.

Kerry was statemented aged ten, having been referred due to concerns regarding her extreme social and emotional behavioural difficulties, which were felt to be directly linked to her mental health. Kerry's subsequent referral to the MBS was primarily due to high levels of aggressive behaviour, self-harm and a view that, while living in the family home, she would be unable to make emotional, social or academic progress. After being placed at the MBS, she was removed from the Child Protection Register.

4.5 Summary

Throughout this chapter, I have provided a thorough context for the case study, including an ethnographic overview of the structure and work of the school. The reader has been introduced to the Education, Group Living and T&NT teams, which exist alongside one

another to form the core parts of the MBS, and the school's governance and management structures. It has been acknowledged that the co-working of these teams is not always easy, yet it is an essential part of the therapeutic approach. This was followed by an overview of the model of practice, with emphasis given to the use of group work as a model of therapeutic work.

The profiles of the children highlight the breadth and complexity of their individual early-life trauma, recognising the different backgrounds they arrive from, and often return to, along with their demographic differences. This chapter highlights the complex range of emotional and behavioural difficulties the children experience and the impact of these on their functioning. The profiles show the complexity of children through a range of known and unknown background information, and the effect of multiple professionals present in their lives.

It is recognised that, despite providing a rich context, this chapter is based on a small number of children and observations. As such, it captures moments in time rather than encapsulating the whole of the MBS. Despite this limitation, these contexts inform the findings and analysis of the data presented in the following chapters.

Chapter Five: The children's journeys to and through the Mulberry Bush School

In the previous chapter, I introduced the MBS as my case study, including the histories of the four children before the start of the study. The purpose of this chapter is to build upon these profiles, presenting the fieldwork findings, the narratives of the participants and their experiences. I will provide extracts from participants' stories, along with observational data to illuminate the detail and complexity of the explored experiences.

After analysing the interviews and observations, and in light of my research questions, five principal themes were identified: the interconnections between children's feelings and behaviour and the subsequent impact upon their understanding and development of relationships; how behavioural changes are viewed and understood to have occurred; how the model of group work is understood and used as part of the therapeutic approach; the intense emotional impact of working alongside children who have experienced trauma; and the wide range of expectations from children, staff, families and professionals about children's progress, including progress made by the children towards emotional self-management.

Although not an identified theme, the therapeutic approach was rarely mentioned by staff and families. Given that this is the central tenet of this study's research question, this lack of reference is noteworthy. All findings presented here relate to these themes and are critically analysed in chapter six.

Although each of the children participated in up to three interviews, they often found directly answering the questions difficult; they changed the conversation, wanted to move around and, on occasion, they left. This means there are fewer direct quotes from the children, but their avoidance of specific topics is significant data and, at times, is presented throughout the findings. Also, although the children have different family backgrounds – Leo and Kerry

reside with their birth mothers, Lola with foster carers and Jamie is adopted – there appeared to be little association between their family backgrounds and the themes identified from the data.

5.1 Emotional trauma, behaviour and family relationships

This theme emerged from my initial inspection of the data on the children's early lives. The children have suffered emotional trauma, as discussed in chapter four, which has had a significant impact on their emotional development. When speaking about the children's life histories, all the parents gave clear examples of significant emotional trauma, including repeated abuse, violence, substance dependency and severe neglect. Their families only partially understood the devastating impact of these traumatic episodes on the children's emotional development and behaviour; consequently, the children's understanding was also limited. It is apparent from the family narratives that, at times, the children's violent behaviour drew attention away from their emotional trauma to their behaviour instead. Rather than acknowledging the possibility of a connection with previous trauma, both Jamie and Kerry's parents described their children's violence as merely being directed at themselves or their siblings. Their concerns appear to be related to family-life disruption, rather than the acting out of emotional trauma.

I think we've experienced a lot of violence. He has smashed our door, windows in several times. He has smashed up two TVs. We both are being punched, had heavy objects thrown at us, so very disruptive. (Jamie's father)

Being spat at, being kicked at pushed down the stairs (...) and it was, 'I'm going to take it all out on everyone in this house.' (Kerry's mother)

What appears most striking is the ongoing emotional impact of children's early-life trauma on the whole family. This raises questions about the need for a more comprehensive family approach to childhood trauma, linking back to a systemic, collaborative model of therapeutic working. Chapter two identified how trauma impacts children's relationships with families and

staff, with Dods (2013) arguing that these children are most likely to test and resist the intensity of relationships, often through fight-or-flight behaviour. This study has also highlighted reflective practice as a central tenet of the MBS, yet this is something to which families do not consistently have access. Staff from the T&NT raised this as an area of work they are keen to develop in the future.

The impact of the children's behaviour on others was an issue not only for their direct families, but also for their wider families. Families reported that home life had been very difficult before placement. Lola, for example, found it hard to play with her foster carers' young grandchildren, and Jamie's parents were anxious about his physical aggression towards other family members. Kerry's mother was concerned about her mother's ability to supervise Kerry, which led to a reduction in the support offered by her wider family:

[M]y mum would always say to me, 'Now she wouldn't do this stuff with me.' But she really hurt my mum. My mum was so shocked that she'd actually done it, 'Well okay. I know you said you were having issues with Kerry...' It shocked my mum that much, and it was, 'Mum, she can't come over to yours because you can't watch her like you're supposed to. That sounds really horrible, but you have to understand... You don't know the little things you need to be looking for.' So, then it was family can't help because they don't know what they need to be looking for. (Kerry's mother)

These concerns were reinforced by interviews with staff members, particularly those working closely with each of the families. The staff gave multiple examples of how difficult home life had been for the families prior to the children being placed at the MBS. Although there was some recognition of these difficulties by the children, they appeared to be unaware of the emotional impact on their families, though Kerry described herself as 'a nightmare', suggesting greater awareness than the other children. However, it could be that Kerry was mirroring the language she had heard adults – perhaps her parents – use when speaking about her.

5.1.2 Perceived lack of professional support for families

The emotional impact on families appeared to be further exacerbated by their perceived lack of support from some professionals. This was particularly apparent when Leo, Kerry and Jamie's parents spoke about incidents of violence which had resulted in police intervention; only Lola had not experienced police involvement as a result of her behaviour. The involvement of police is an example of professional interactions with families, whereby parents felt the professionals did not always fully recognise the severity of the children's difficulties and behaviours. Furthermore, all parents commented that they felt professionals, prior to the MBS, showed limited understanding of the impact of early-life trauma on their child's behaviour. This appears to contradict their own limited understanding of the relationship between their child's emotional trauma and subsequent behaviour, perhaps indicating a greater awareness than they verbally indicated, which may be part of their own psychological defence against the impact of the child's trauma on themselves. An alternative explanation may be that, having worked alongside MBS staff, they project onto other professionals what they themselves have not fully understood.

Parents wondered how they were perceived by professionals and often expressed that they did not feel considered as equal partners in care planning for their child. There was a strong narrative that, where violence was a factor, they were treated as failing parents who should have been able to 'manage or discipline' their child. They described how some professionals gave limited recognition to the impact of the children's early-life trauma, and the link to the child's current behaviour, leaving them feeling judged and questioning their mental health:

I was like, 'I'm not thick. I'm just tired,' you know? 'Just don't speak so fast. You're all speaking at once. I haven't slept for three days' (...) It was like, 'Well, Mum must have mental health issues. We need to get her assessed' (...) 'I'll do all your tests and whatever you want me to do, but you're not listening. I'm tired.' It was a bit of a crazy time. It does question your mental health I must admit. (Kerry's mother)

The children made little reference to previous professional involvement, though all described previous schools and social workers in ways which suggested not being understood – for example, Kerry highlighted previous Social Services involvement:

[S]he used to ask me all these things, but they didn't know what I was thinking, they didn't help me.

The perceived judgement of their parents and lack of professional support, coupled with managing the emotional impact of the children's trauma on themselves and the wider family, had a significant effect on parents and carers. Parents suggested a sense of frustration that professionals were unaware of the complex needs of their child, yet this often matched their own limited understanding of the reasons behind their children's emotional and behavioural difficulties, and a sense of relief that the MBS was now managing these, as discussed in the next section.

5.2 'Sense of relief'

Although parents and carers responded differently, they all expressed huge relief concerning their child being placed at the MBS. Both Leo's and Kerry's birth parents talked of being overwhelmed before the placement, while Lola's foster parents and Jamie's adoptive parents appeared less overwhelmed, yet still felt what Jamie's adoptive mother described as being at a 'loss of what to do':

On the day that we came here, we also visited beforehand, in order to manage the transition from home to here. I would say that I felt relieved as well, that we were free from that stressful atmosphere that we had been in (...) our initial reaction was one of profound relief. (Jamie's adoptive mother)

Without exception, this relief sat alongside a sense of guilt for the parents and carers, often expressed through frustration at practical arrangements once the child commenced their placement. For example, Lola's foster carers spoke of 'feeling guilty when she phoned us

and got upset', while later recognising that this had been hard to share with staff. Instead, they appeared to be avoiding the guilt and focussing on their frustrations about more practical things, like missing clothing.

However, the parents' and carers' relief was noticeably different from the children's feelings. The adoptive and fostered children appeared more accepting of being placed at the school than those residing with birth parents – a pattern which was also apparent from the staff interviews. This can perhaps be explained by the different attachments between child and birth parents, and child and adoptive or foster carers. These children's responses were, not surprisingly, more pragmatic – for example, when asked about moving to the school, Jamie described the environment in detail but did not mention his emotional response:

The first thing I saw was the door and the football table. Then I saw the door, and I thought that was the door to the main bit, the houses and all of that, but then when I actually got out, I knew that I had to go that way.

When trying to explore their emotional responses to moving to the school, all the children responded with comments such as, 'I can't remember anything else' (Jamie) or 'I'm not good at remembering' (Lola), and listed the activities or facilities that the MBS provides, compared to their previous school. Again, this was a pragmatic response to the question – perhaps a defence against acknowledging how they felt, but potentially an insight into the children's struggle with knowing their feelings.

Parents felt overwhelmed, and they all described not knowing what would have happened if the MBS had not offered their child a place, giving a sense that this was the last chance for their child and their family:

He was very angry. He was hard work, in general. He really did have to come to this. The Mulberry Bush was the last resort, really. (Leo's mother)

This relief also appeared to impact what information parents and carers were able to hear about the school, when it was shared before the placements. The parents of Leo, Kerry and

Jamie all gave examples of aspects of the school they felt they did not know about – for example:

I could've been told lots of stuff, but I just needed somewhere for him to be safe.
(Leo's mother)

Some parents were able to identify that they had been in an emotional place, where they would have accepted any placement that would work and not exclude them. Internal documentation and staff interviews supported these views. Perhaps the most extreme example of this was from Leo's mother:

I had no idea the school was so far from here (...) I thought he'd come home every weekend, so that was a shock.

Kerry's and Jamie's parents also shared surprise at some of the practical arrangements, such as term dates, but the data identifies that this information was shared with them; with support, they recognised that they had been told, but had been unable to hear what was said. Interviews with staff also highlight that carers, particularly birth parents, had been unable to hear everything about the school. Lola's foster carers were the only parents who did not highlight areas they felt they did not know about, again suggesting that the emotional experience for birth and adoptive parents of living with their child was so intense that it prevented them understanding or taking on board information about the placement.

Concerning the reasons for being placed at the school, the children's responses were noticeably different from those of their parents and carers. There was no distinct sense of relief for the children, who held the view that they had been 'naughty' (Lola) or 'a nightmare' (Kerry) in previous settings. All the children were more factual, giving a clear and relatively accurate account of their previous educational and, where relevant, home placements. All the children recognised that they had been excluded for behaviour-related reasons and that a new school was required. They expressed a limited degree of emotion about attending the

MBS and its location, again responding with 'don't know' answers, but acknowledging that local schools had not worked. This contrasts with their parents' relief and guilt, which was perhaps one of the most striking differences from the interview data.

5.3 From feelings to behaviours to relationships

The links between feelings, behaviours and relationships were consistently clear from the interview data and matched documentation relating to the school, discussed in chapter two. Before coming to the MBS, all the children were unaware of their feelings and of the impact of these feelings on their behaviour; this was evident from the interviews and documentary evidence for each child. The MBS's process to enable children to become aware of their feelings, and the impact of emotions on their behaviour, is outlined in chapter one. The data suggests that the children's capacity for understanding improved significantly during their placements, although based on staff feedback, the amount of change and capacity to understand varied between the children. This correlates with the literature relating to children in the care system, which highlights significant variations in children's emotional development from being placed in residential care settings (Hart *et al.*, 2015).

5.3.1 Awareness of their own feelings

There was a strong narrative that the children developed the skill of recognising their feelings during their placements at the MBS. Parents and staff, and to a far lesser degree the children, highlighted that the process of naming these feelings had enabled the children to become more aware of their own feelings. Although Leo, in his interviews, was not able to verbalise an awareness of his feelings, this seemed implicit from my observations of him:

Leo again came to my office door today telling me that another child had said something in class which had made him cross (not his words!). He had stormed out

of class to take some space, so he 'didn't end up hurting anyone'. (Extract from field notes)

Only Jamie and Kerry described being able to recognise their feelings, but there was significant evidence from families, staff and observations that all four children developed significantly in this area. Kerry acknowledged the positive impact upon herself:

Now I can ask for hugs. Sometimes I talk about my feelings.

This appeared to be a significant achievement for Kerry, who before the MBS was perceived to be 'unaware of her feelings and her behaviour' (Kerry's mother), and was similar to responses from Lola, who appeared to be starting the process of recognising her feelings:

Sometimes the grown-ups tell me what I am feeling, and they're wrong, and I tell them I'm not cross, I'm feeling worried (...) Sometimes the grown-ups get it wrong and don't know how I'm feeling, but sometimes they know, especially J [female therapeutic care practitioner] (...) sometimes she just knows.

The children's growing awareness of their feelings was a particularly strong narrative among the staff. They gave multiple examples of how each child had developed since being placed at the MBS:

I think Leo's self-awareness is definitely one of the most predominant changes in him. His ability to identify, not all of the time, but an increasing amount, that, 'I am cross, and I just need to take some space. I can sort of understand this feeling that is inside me now, and I know what it means, I know that I can get through it. I know that adults can support me to get through it, and I know that I can think of strategies that will help me as well.' And that has been really significant. (Male therapeutic childcare practitioner working with Leo)

When Kerry sidles up next to you and asks you for a hug, and you embrace her, you feel like you're embracing her, whereas a year ago if she nuzzled up next to you and head-butted you, which was her way of asking for a hug, you'd feel like you were embracing a shell (...) she is also able to support other littler children that experience the same things in a big sister-y way. (Female therapeutic childcare practitioner working with Kerry)

Lola is more able to communicate on her own without relying on other people to do that for her. She is more able to be clear about what she wants. She is more able to say no (...) she's made lots of progress, I think, in terms of her understanding of her

feelings and is beginning to make progress now with talking to people about her feelings. (Lola's teacher)

This is supported by internal school documentation in the form of assessments of emotional development, and corresponds with other research undertaken within the school (Gutman *et al.*, 2018; Harriss, Moli *et al.*, 2008; Price *et al.*, 2018).

Furthermore, there was a strong indication of the children's growing ability to understand the feelings of others, particularly family members and other children at the school. This represented a significant development for the children, many of whom had been described, before placement, as being completely unaware of the feelings of others, and the impact they had on others. This was evidenced by Kerry's mother:

My main one is her realising that other people need help and she's not the only one really. That's obviously given her the boost to take a step back and think, 'Okay, yes, other people do need help before me. I am going to get the help eventually.'

Kerry's teacher also discussed her increasing ability to show her feelings and allow adults to support her with them:

In class she could appear cross, and certainly by the second or third week at the school she became cross two or three times and started to allow staff to see this. Over time she has made lots of progress, I think, in terms of her understanding of her feelings, and is beginning to make progress now with talking to people about her feelings.

This matched the view of Lola's foster mother, who spoke about her limited ability to recognise her feelings before attending the MBS:

[S]he really doesn't, and if she falls over, and this was right from when we first had her (...) 'I'm alright. I'm alright.' It's like she has not been allowed to be upset, whereas now she's not as angry as she was. We don't see that. She'd get so angry, and then it would come to a (...) like a volcano (...) I reckon, probably, she still gets angry sometimes, like we all do, but I think she's learned how to control her anger better and she just doesn't.

The children spoke little about recognising their own feelings and those of others, despite being asked. They all seemed keen to move the discussion on at this point, though interestingly they were more able to talk and recognise some of their behaviours.

5.3.2 Impact on behaviour

In the initial child interviews, the children were asked why they thought they had come to the MBS, as well as how they thought their behaviour linked to their feelings, thus linking directly to the research questions. All four children recognised that their behaviour caused difficulties, but made limited, if any, connections to their feelings. Lola, the youngest child, was unable to understand why she was at the school:

I don't know why I'm here. I don't struggle like other people.

However, the interviews prompted the recognition of some negative impacts of the children recognising their feelings, primarily relating to Jamie. For example, his keyworker highlighted that he had said:

But I hate it when it changes, when stuff changes. I don't know, it's just the change of it gets me all fizzy (...) hurting and punching.

As with other children, Jamie became more aware of his feelings during his placement, but rather than this correlating with a reduced level of behavioural difficulties, he recognised increased levels of physical aggression, both at school and at home:

My restraints have been going up and up since I've been here. When I first came here, I was fine when I was in Rainbow, and a few months when I was in Pegasus. I don't know what happened. I just get more angry since M [his keyworker] left.

This insight was reinforced by staff and his family, and appeared to relate directly to periods of change, particularly the loss of relationships, his own struggles with being in touch with relationship loss and the feelings associated with this:

We've had to call the police each holiday (...) because he's become much more aggressive. He's punched me, kicked me, thrown a glass bottle at my head, and I think it's not that he's changed, as such, it's just that that part of his personality, which we knew about before he came here, has now been evidenced here as well. (Jamie's mother)

This apparent deterioration in behaviour as the child becomes more emotionally attuned to their feelings and history is not uncommon at the MBS, or in the broader field of therapeutic work with traumatised children (Sharpe, 2019)(Sharpe, 2019). Several members of staff have observed this with children involved in this study and other children at the school. There was evidence from the school that, as children neared the end of their placement, when they were generally more in touch with their feelings, their behaviour often deteriorated. Some children returned to behaviours they exhibited when they first came to the school, showing more of an emotional awareness of their feeling and actions. Jamie's mother acknowledged this when she described an incident when visiting the school:

He would clench his fists and breathe deeply and say, 'I'm really cross.' And he did say to me once, and it seemed quite genuine, he was sort of half upset, half angry, and he said, 'I really want to hit you, but I don't want to hit you, and I don't know what to do.' I said, 'Well, that's honest, okay.' So, I think there were times when he wanted to, and I suspect if he had been at home he would have, but he didn't here.

Both Jamie and his mother appeared to be aware of his internal struggle between acknowledging his feelings and acting on them. The documented evidence indicated no such emotional awareness before his placement at the MBS, suggesting significant progress in this area for him.

Such struggles and progress were not always as apparent. For some of the children, there was concern about them holding their feelings in and learning how to share them appropriately. While Lola and Jamie appeared to develop the capacity to acknowledge and verbalise their feelings, responses indicated that this was more difficult for Kerry and Leo. A female therapeutic care practitioner working with Kerry highlighted this:

The difficulty is that Kerry doesn't tell anyone how she's feeling. It feels positive that she's not going around smacking people in the face, but I would like her to get to a point – and she may be at this point already, I don't know, in the house – where she can say, 'I'm really pissed off about that' or 'I'm really upset about that' or whatever it is. Because I've seen her in situations where I think, 'God if I were you, I would be absolutely furious because this is rubbish,' and she doesn't react to it. So I'd like her to get to a point where she can trust that how she feels is important and that other people also think it's crucial and will respect that.

Kerry also had difficulty verbalising her feelings at home. Here is an example of how a member of staff helped her to apply the ability to recognise and talk about her feelings outside the MBS:

Kerry asked to see me a couple of months ago; she had asked a member of staff if I would go over and talk to her. So we sat, and her big concern was: she was going home for the weekend, and she didn't know how she was going to explain to the family if she was upset or she was angry. So we looked at different ways that she could say 'I'm this' or 'I'm that'. So I put together a keyring very quickly, because it was the following day, with faces on it. Depending on what emotion she had, she could then show them this emotion card. And so that helped her to say to Mum, 'Do you know what, I'm really angry, and I want some space.' So she would, without verbalising it, take herself off to her bedroom for ten minutes and then would come back and join the family again. So that changed completely. (Staff member working with Kerry's family)

All four children were able to name examples of challenging behaviours and, to a limited degree, recognise that they had felt cross or angry at times. Both boys blamed other children or adults, including parents, for the specific examples, but were unable to make any other meaningful links. Although neither of the girls blamed others, in their first interviews they could not recognise or verbalise any links between feelings and behaviour. They presented more pragmatically: 'I was cross, so I kicked him' (Kerry).

Further into their placements, the children made limited links between their awareness of how they were feeling and how this linked to their behaviour. However, they were all able to recognise that their 'behaviour had improved' and that the number of aggressive incidents had reduced (or stopped altogether), as had many other negative behaviours. All four

children were more able to recognise and feel proud of this progress, and for some, such as Jamie, even to laugh at how they used to behave!

I used to swear a lot, but now I don't swear that much. Well, I don't swear nearly at all. (Jamie)

All the children were able to describe what made them cross or annoyed, how this felt and how they were now able to respond:

I used to have lots of incidents, I had four, then I had two, and then I'll have one and then none. If I get cross now, I...I think probably I'd either cry or I hit a pillow. (Lola)

Using a 1-to-10 scale with each child, they were able to highlight how they could recognise how they felt, name these emotions and subsequently find alternative ways to manage them. These strategies included 'taking time away from things, or people', 'talking to an adult' about how they were feeling and 'using the play equipment by the hall'.²⁷

All the children were able to describe their behaviour and recognised that, at the point of placement, it had been inappropriate and negative, but none of the children showed any emotional link; instead, they described a set of events and behaviours factually. Lola had previously commented to her carers:

Am I really that bad? I must be bad because I was sent to the Mulberry Bush School, a long way from home.

The narratives from the family also showed an improvement in behaviour, and parents were able to see the link between their child's self-awareness of their feelings and their behaviours.

²⁷ This 'play equipment' includes spinning poles and a hammock, and is specifically designed to enable the children's bodies to regulate when they become overwhelmed.

The parents' views about the child's behaviour at the point of referral corresponded with those of the children. For example, Lola's foster mother also mentioned how Lola was unable to recognise all her behaviours:

I don't think she sees herself as having challenging behaviour or anything. I think she sees herself as quite compliant and being quite a good little girl (...) Part of it I think she has quite openly voiced, part of it is that she believes that if she is a good girl, then she will get to be at home. (Lola's foster mother)

This response highlighted how the children often viewed themselves as naughty or bad, rather than as behaving in a way which reflected their early-life trauma. Staff working with Lola also felt she held a view that if she was good, she would return home, while Lola herself said, 'I don't hurt people like some of the other children do'. When asked why previous placements had ended (she had been excluded for aggression towards teaching staff), she expressed that previous schools were 'the wrong school'.

This narrative was supported by my own observations, which indicated a reduced number of physical interventions for each child; when interventions were required, their duration was significantly shorter. During the early stages of data collection, I observed both Leo and Jamie becoming physically aggressive, damaging property, trying to hurt staff and requiring physical intervention. Reflecting on these occasions, both children later recognised their aggressive behaviour, but maintained a clear view that it was the fault of members of staff:

[W]hile staff supported Leo, he shouted, 'Go on then, fucking kick me out, you'd like that...' Staff wondered aloud to him whether this was his worry, the fact that other schools had 'kicked him out'. He seemed to sink into himself at this point, almost relieved that someone had named something for him (...) after almost 20 mins of Leo's angry outburst, he sat with staff on the sofa in the library. Although he said he 'didn't want to talk', he seemed to say quite a lot to staff, though it seemed factual and not related to the incident. Leo spoke about what he could see – books, a poster, the head teacher coming in and out – but despite staff efforts to wonder how he felt, he seemed to avoid this. (Extract from field notes)

Subsequent observations of both boys showed a marked difference. On one occasion, Leo stormed out of the classroom, swearing at staff and slamming the door, but within a minute or two he brought himself back into the classroom, sat at the desk and was able to allow a staff member to support him. Similarly, I observed Jamie running out of the house, clearly cross and distressed, towards the climbing pyramid. A member of staff approached him and sat at the bottom of the pyramid, asking him what had happened and saying that he looked angry. Jamie replied that he 'was angry because K [another child] had interrupted me and said something I wanted to say'. The staff member empathised with Jamie, saying that this 'must be frustrating', but that it was positive that Jamie had run out and taken space rather than resorting to violence. At this, Jamie's body language changed, he looked calmer and he climbed down and walked back into the house with the staff member.

This idea of naming to the children what they might be feeling is a core part of the work of the school and was discussed by staff in relation to all four children:

The work with Leo has been like that. It's if you can put your finger on what is wrong with Leo in that moment. 'You're hitting people because you haven't apologised to J yet...'. (Male therapeutic childcare practitioner working with Leo)

Staff in both the classroom and residential provision spoke of the need to wonder aloud and make suggestions to the children about what the children might be feeling, and why, and then to use this to help them make sense of their behaviour.

I have found with Leo 'really boring' means one of two things. It either means, 'I don't know what the hell I'm expected to do here' or it means – well, they come together – 'I'm really anxious, either about the way this group is going to turn, who's in charge of this group, will I be able to do the work?' It's anxiety-based and 'really boring' is a keyword that explains how Leo is feeling. 'Really boring' means, 'I'm really [laughter] anxious right now.' (Male therapeutic care practitioner working with Leo)

The narrative around feelings and the links to behaviour was more emphatic from staff, who spoke positively about the changes they had seen with each of the children. Staff regularly

used phrases such as ‘can recognise when she’s cross’, ‘understands his own triggers’, ‘is more in touch’, ‘can control his aggression’ and ‘has other strategies’ when discussing the correlation between self-awareness of feelings and links to behaviour.

Staff observations differed noticeably from those of children and parents regarding whether behavioural changes were interpreted as positive and negative. For example, staff spoke about both Lola and Kerry’s increasing rudeness towards others, which, although inappropriate, was considered to be a positive step for them both. However, Lola’s foster carers and Kerry’s parents were more alarmed at the increase in their child’s rudeness.

Staff working with Lola and Kerry specifically commented that their aggressive behaviours towards others had been a significant factor in previous exclusions and their subsequent placement at the MBS. There was a shared recognition that both girls were more able to recognise how they felt and less likely to revert to aggression, even when cross. Kerry had no incidents of recorded aggression during her placement at the school and Lola had only a small number towards the start of her placement.

These changes were good examples of how the children’s behaviour was viewed using the school’s theoretical underpinnings. For example, rudeness was considered to be positive, a communication of need from the children, and was worked with as such, whereas previous placements had viewed this purely as a negative behaviour, or the children’s rudeness had been accompanied by physical aggression.

5.3.3 Relationships with peers, staff and family

The impact of children’s developing self-awareness of their feelings was further highlighted in their ability to develop and maintain relationships. Initial interviews with children, staff and

parents highlighted the difficulties all the children experienced with relationships because of their early-life experiences.

[S]he's most of the time on her own or most of the time in the corner, while no one's really paying much attention, because they're just either watching TV or something else or she's reading a book. (Female therapeutic childcare practitioner working with Lola)

Both Lola and Kerry recognised their struggles with friendships and described themselves as not having good friends, either at school or at home:

I don't have any best friends. I don't even have any friends. (Kerry)

However, the two boys briefly described themselves as having a wide circle of friends and as getting on well with children at school and at home. Neither of them was able to elaborate on this point, appearing keen to move on to a different subject, almost like an unconscious tactic to divert attention from discussing the issue. Interestingly, these views were contradicted by their families and staff, who described the boys as having no real peer relationships. Instead, the adults reported that the boys wanted to socialise with children who were often older and involved in delinquent behaviour, regardless of their parents' wishes. This may relate to the children's limited sense of self, of having an unconscious need to boost their own self-image, though it may also be as simple as different interpretations of 'friendship' between children and adults.

Another difference between the girls and the boys was how they spoke about developing relationships with staff. Both girls initially spoke about finding it hard to make strong relationships with staff, particularly male members of staff, which may relate to the trauma they experienced in their early lives. While Kerry felt she did not have relationships with staff, Lola was somewhat more explicit, responding, 'I don't trust the grown-ups'.

Both boys described themselves as having several good relationships with staff members, though, interestingly, not with their placing social workers. The boys felt they got on with both male and female members of staff both in the house and in class:

I get on with all of the adults, I reckon, not like some of the other kids. (Leo)

This view was repeated when I later met with Leo, who still felt the same, though Jamie's perspective had changed a little. During our second interview, he was able to identify some adults, two females, whom he did not get on with, describing them as 'not helpful and bossy'. Initial interviews with staff teams indicated that they viewed their relationships very differently. Staff expressed that both boys were starting to test them to determine who was trustworthy and safe, often by physically testing boundaries to see which staff could stop them or keep them safe.

And the less invested he is with it, as well as the less safe he feels with them because he also feels safe with you – he knows you will stop him, you can stop him – if he doesn't have those two things in other relationships, then he doesn't feel as self-contained, and therefore he is far more willing to make some pretty negative merging, delinquent, destructive, self-deprecating decisions. And some of those can involve some pretty extreme behaviours. (Male therapeutic care practitioner working with Leo)

Staff acknowledged that there was a separation between how the children related to male and female members of staff. For example, a female member of staff working with Kerry, whose early-life abuse had been perpetrated by her birth father, said:

Yes, she is far more relaxed in the relationships with the men that aren't the daddies but are the playful boys, whereas the men that represent the daddies, she'll get on and she'll tolerate, but you're safely held at arms' length.

These views matched my own early observations of the children, when I observed that Leo, Lola and Kerry were mistrustful of me. On several occasions they came to my office door,

sometimes to look and see if I was there, but sometimes to ask, 'Have you still got those recordings? Did you play them to anyone?' even though they had been assured of confidentiality. This was understood to indicate a lack of trust from the children towards myself, either as a researcher or simply as an adult. This seemed different with Jamie, who was more accepting of me; he spoke to me in the corridor and only once came to my office to say, 'Hello, are we still meeting again soon?'

All four children had different family relationships and spoke about tensions at home: how they argued and physically fought with their parents. However, Kerry and Leo were noticeably different: both touched on wanting to be at home, even though they found it hard, suggesting that a strong relationship existed between them and home. They were both keen to move on from this discussion point. It appeared to be too emotionally painful for them to explore:

I just wanted to be at home. I couldn't wait for the weekend home. (Leo)

It is noteworthy that both Kerry and Leo, who reside with their birth families, potentially indicated a stronger relationship than Jamie and Lola experienced. This was reinforced by the views of staff working with Leo:

[H]e values so much the relationships that he has at home, to the point that if something does go wrong, if he has an incident at the school, one of the first things that he is worried about is how his Mum is going to feel about it, how his brother is going to perceive him. (Male therapeutic care practitioner working with Leo)

Lola spoke more pragmatically about her foster carers, indicating that she had only been with them for a few years, while Jamie appeared confused about his relationships with his adoptive family – on the one hand, he cared for them, yet he was explicit that he wanted to live with his birth mother. The parents/caregivers of all four children spoke of the extreme difficulties in their relationships. However, all indicated positive changes.

The participants' views about relationships changed considerably during the data collection period. The final interviews suggested the children had made significant progress in their ability to develop and maintain relationships, and showed insight into why and how they related to some people more than others. All of the children described having friendships both at school and at home. When Jamie and Kerry were asked who their friends were, both responded 'Everyone!' while Lola seemed more cautious and tried to work out who were friends and who weren't:

I don't have any best friends (...) but I have friends. Ben is just someone I can trust, not a friend.

Some of these friendships were more transient than others, supported by the views of staff members:

Her relationships with her peers feel very much linked to what threat she perceives from them. If there isn't a threat of violence, I think she is prepared to be pretty close and pretty fun with people. (Female therapeutic care practitioner working with Kerry)
Staff related this directly to Kerry's early-life experiences of violence, which also links with comments made by staff working with Lola, whose early experiences were strongly linked to her brothers. This excerpt identified Lola's sibling-like relationships:

She has got quite positive sibling-like relationships with the three older children. It feels like she is exploring these sibling-like relationships in a really safe and contained way and she lets them look after her. (Female therapeutic care practitioner working with Lola)

Parents also recognised the development of peer relationships, both within the school and when the children were at home:

She says she has got some friends. I can't remember their names. Yes. She seems to have a little group of friends that she really gets on well with. (Lola's foster mother)

When looking to the future, staff and families spoke of the children's increased ability to develop meaningful peer relationships, and their developing ability to recognise, to a limited degree, which peer relationships might be positive and to act on this:

He'll probably have, hopefully, looking forward, a much stronger ability to build peer relationships, and maybe even identify people that aren't going to be positive relationships, and maybe make choices about who becomes a friend and who doesn't, rather than just everybody is here and that's life. (Leo's keyworker)

This suggests that the children's ability to develop and maintain relationships increased as the placement progressed, a point highlighted by the children, their families and staff. The children's relationships with staff were also described as improving. Relationships with men and women seemed healthier than when the children first came to the school. This suggests that the process of being alongside adults, where care and education were shared, was essential for the children to recognise that they could form relationships with both men and women:

He's built relationships with most of the females in the house, and it doesn't matter hugely anymore. J was the predominant one for a long time and probably still is top. (Female therapeutic care practitioner working with Leo)

This links directly to the section above, as well as the theme of self-awareness of feelings; the children were more able to link their feelings to their behaviour and relationships:

[I] had a lot less incidents and am able to tell some people how I'm feeling because I know the adults now, before I didn't. (Lola)

Importantly, staff and families viewed this growing ability to develop relationships with staff as a stepping stone; it enabled the child to fully engage in the therapeutic nature of the placement:

Now that we have formed the relationships with her, I think now we can get into the nitty-gritty of, 'Okay, so this is who you are. What is your identity about? Where has it come from? Who do you want to be? How do you want to get there? These are some

bits about you that aren't very sociable, let's help you understand them and think about coping with them.' (Female therapeutic care practitioner working with Kerry)

At times it seemed to be the strength of the relationships which allowed the children to get in touch with their feelings and exhibit them safely and securely. For example, Kerry had been described as not showing any of her previously identified difficulties – something which had frustrated staff. However, staff felt that building relationships enabled her to become more 'real':

She is asking for help more when she needs it and when she wants it. She is stropping more. She is being prepared to be rude to people (...) Now she is opening up and doing the things that we want, and we want her to get it out. (Kerry's keyworker)

It was also recognised by staff that this emotional work was the start of a long developmental process for the children – one which would run beyond their time at the MBS.

So, I think she's trusting us and making those relationships with us, but it's just really early stages for her, on the cusp on it. (Female therapeutic care practitioner working with Kerry)

Given this study's focus on relationships, it is noteworthy that the children's improving relationships with peers and staff also correlated to their relationships with their families. In early interviews, some of the children had been dismissive of their family relationships, whereas now they spoke about them more positively. Lola commented: 'Now I call my foster dad my dad.' Jamie's descriptions of family life differed the most from the other children's; his interviews indicated an important yet strained relationship, and he fluctuated between talking fondly of home and appearing angry and dismissive of his home relationships.

Both Kerry and Lola spoke about looking forward to returning home for the holidays and their improved relationships with other children at home, in the broader family and living nearby. Both were able to give examples of positive family interactions, but perhaps more

significantly, they were able to describe that they still got cross and annoyed at home, but were able to deal with this in a manner which did not blame family members or result in negative behaviours towards them.

Leo still spoke favourably about going home and family relationships; he was unable to give specific examples of what was different. Nevertheless, his family and staff members working with them provided multiple examples of how his relationships with his family had improved. However, the relationships between Jamie and his family remained very strained. He spoke about not wanting to go home and disliking his family, which was also raised in interviews with his family and staff working with him. Both are discussed in the following chapter.

One interesting aspect which came to light after the second phase of interviews was how families were now able to socialise more. At the point of placement, they had all found it difficult to take their child into social environments – for example, Lola had thrown herself onto the floor of a shop and screamed, while Jamie had, on multiple occasions, become aggressive at a local park. After the second interviews, parents described a significant change in both behaviour and relationships:

She used to get very angry. Such an angry little girl inside, but she seems to be, I don't know, happy with her little world now. So, now, her behaviour is getting better every day (...) Her behaviour has improved so much. I can take her anywhere now. Anywhere (...) Perfect. I could take her to a top-class hotel, top-class restaurant. I know she's not going to do anything she shouldn't. (Lola's foster mother)

An unexpected narrative which arose from both birth families was their growing relationship with the school. Previously, they had described feeling judged by professionals and feeling unequal to them, yet by the second interviews, both birth families described strong relationships with staff at the school.

We're always made aware who we can call, and I feel like I can call them without feeling like I'm annoying them or constantly ringing them. It'll be... I don't have to say,

'I know it sounds silly' or 'I know it sounds stupid'. I don't have to say that. It's, 'This is what was happening. What do you think about this or this?' 'Well, give it a go', and it's nice to have somebody to bounce ideas, and it's nice to have the support.
(Kerry's mother)

Both Lola and Jamie's family described the support they received from the school, but this seemed less significant than the potentially dependent relationships formed by Kerry's and Leo's mothers:

I'll be honest with you, they've been great. I don't know what I'm going to do when he leaves. I don't reckon the next school will be like that. I've always been able to call and speak to someone, even in the holidays. (Leo's mother)

The views elaborated during the interviews matched my observations of all four children.

When the children first became involved in the study, I often observed them on their own or alongside an adult; peer group interactions appeared awkward or gave way to behaviours which led to them being removed from the group and, by default, relationship situations.

However, later interactions and observations showed them to be more able to interact with peers and staff members. This was particularly noticeable in whole-school activities, for example:

During sports day, I was able to move freely around the school's front field, observing all of the children's interactions. Last year, both Leo and Kerry had refused to join in their events, but today they both joined in, sat with their group and encouraged their peers. Although Leo was frustrated when other children weren't as good as, he felt, he was, he still cheered them and patted them on the back. Kerry was particularly supportive of the younger children, getting them drinks and taking on a 'caring' role with them. (Extract from field notes)

Observations of the children further highlighted significant changes in their behaviour. Leo and Kerry, both of whom lived with their birth families, were often rude and dismissive when they saw me outside of the planned interview sessions, but by the end of the research, they were able to stop and talk with me in a manner which recognised our developing relationship and, more importantly, highlighted their growing sense of comfort in engaging with others.

This correlates directly to the MBS's core work, and this study's research question, relating to children's developing capacity to understand and regulate their feelings.

A further example comes from two occasions when the children's parents arrived at the school to collect them for a school holiday. On the first occasion, both children were clearly uncomfortable with their families talking to me, or even acknowledging that I was in the vicinity. My research notes suggest that Leo found it unbearable for his home and school lives to link. He particularly identified being involved in this study at the MBS and his mother being involved at home as unbearable, yet by the end of his placement he was able to tolerate the different areas linking together and communicating. This seems to parallel his growing ability to link together his feelings, behaviours and relationships.

5.4 From home to school – 'where do I fit?'

The children's difficulties with seeing school and home working together link closely to the theme 'where do I fit?' All four children recognised that being at the school was a different experience from being at home. For example, Lola and Leo indicated a degree of homesickness and an inability to understand the residential home structure when they first came to the school – something highlighted by their families and staff at the MBS:

I remember when I started, I didn't like it (...) my mum wasn't here, and there were loads of adults. (Leo)

Although Kerry's and Jamie's responses indicated that they did not feel homesick or miss home, their parents described multiple phone calls in the first weeks of the placement which, following separation, noted some distress among the children and their families. For example, when explaining how she felt arriving at the school, Kerry said, 'excited, I love school', which was at odds with her parents' recollections:

It was phone calls every day where she was crying. That was hard because you weren't with her, but you had to calm her down over the phone. (Kerry's mother)

Jamie also highlighted that he was 'nervous and excited' when he joined the MBS, whereas his parents recalled him phoning them and asking when he could come home.

5.4.1 Hierarchy, authority and relationships

The structure of the residential staff teams was a strong narrative identified from the participants. This was particularly apparent in the case of Leo, who lived with his mother and brother but had little contact with his father:

I remember I just started, and I didn't like it. Because my mum wasn't there, my family wasn't there. It wasn't normal. Because when I was at home I would just wake up, walk through the corridor, and there was my mum, but when I was here I didn't know who was here or who was in charge. (Leo)

Staff reported that Leo liked to know the hierarchy, or order, of the adults – who was in charge and who was new, for example – and he responded well when male staff members were on shift, perhaps because, in his opinion, he viewed them as 'father figures':

I think he likes to know what the order looks like and then he'll fit his way into there, like a family. (Kate, Leo's residential team manager)

It is worth recording here that Leo was the only child who did not have a father living in his family home. With such a small sample it is difficult to interpret this point, but consideration could be given to the children living at the school who are from single-parent homes and how this may link to their sense of identity.

Jamie's approach was different:

He's got his own sort of hierarchy. The more disciplinarian style, very boundaried staff: he can't bear it, and he will say that he hates them, doesn't matter if they are male or female (...) I do remember him saying to me before that it reminded him. I

don't know who it reminded him of, because he didn't say a name, but he said, 'It just reminds me. When people shout at me like that, I just don't like it.' (Female therapeutic care practitioner working with Jamie)

The staff talked about Jamie and Leo's apparent need to understand the hierarchy and when they might or might not think of challenging authority. The residential team manager for Leo discussed this:

His confusion was compounded by the fact there was no established order. He was incredibly puzzled over a conversation he had with me, that I could be challenged by members of my team,²⁸ something he couldn't relate to his own family.

The concepts of order and authority link to my own observations of the children's interactions with their families. For example, at the end of the first term, towards the start of the children's placements, I sat in the reception area and observed the families collecting their children for the holiday. I noted that the children's behaviour changed when they met their families, suggesting that they presented in different ways to different people:

Kerry appeared anxious about leaving and kept forgetting things; she returned to the house at least three times 'just to get something', leaving her mother waiting with a staff member (...) Jamie's demeanour changed when he left; he appeared sullen and more dismissive of his keyworker, who later told me he had not wanted to go home (...) Lola changed; she appeared to revert to a much younger child, running up to her family for a hug and becoming physically clingy to her foster mother (...) Leo changed the style of his hair, became ruder to staff members and almost strutted out of reception, ignoring his mother, who asked him to say goodbye to his keyworker. (Extract from field notes)

When this issue was raised in staff focus groups, staff acknowledged that all the children behaved and presented differently when at the MBS and when at home. It was highlighted that both boys presented differently within the MBS, between their house and their class.

²⁸ Traditional therapeutic communities have a flattened hierarchy which, although not replicated within the MBS, does emphasise staff members developing their personal authority, regardless of role.

I observed the children being collected by their parents approximately one year after the first time, and saw a marked change in all the children:

Leo was jokey with his keyworker and happy for his mother and keyworker to share a conversation and to walk to the car together (...) Kerry gave her mother and sister a big hug and couldn't stop talking, telling them all the things she had done, but perhaps more importantly, the things she hoped to do over the holiday with her family. Her anxiety appears to have gone (...) Lola appears much more grown-up (her foster mother greeted her with 'Hello, young lady', which Lola smiled at) (...) Jamie's interaction with his parents was confrontational; he verbalised that he wanted to stay at the school. He took considerable support from the staff to leave the school with his parents. (Extract from field notes)

After this second observation, Kerry, Lola and Leo all had excellent holidays with their families and engaged in numerous family events. However, Jamie's keyworker reported that his holiday had been challenging, and he appeared to be reverting to aggressive behaviours which his family had not seen for over six months. From my second interview with the staff team:

He said the other day, 'I just want to be with my mum, with a normal family, with the other children.' I think he just sees Jo [adoptive mum] as this big obstacle in the way, and he powers his hate into that (...) to go back to his 'planning' sense, I think there's this idea that if he acts out sufficiently, if he is sufficiently aggressive, he will be removed from his adoptive parents, or they won't want him. Then, he'll go back to Mum. (Female therapeutic childcare practitioner working with Jamie)

However, Jamie's case is particularly complicated. While he verbally distanced himself from his adoptive family, staff recognised his continued emotional attachment to them:

I remember at Christmas, his adoptive mum sent him an advent calendar, like a home-made one, that had little notes in each day for him. He didn't say, 'Oh, I really love it.' But every morning he would show us his note, and that felt very important to him. So, you know, there was something there that he was thinking about them. (Jamie's keyworker)

For the children, the transition between home and school, which is structured to provide a homely environment, is more complicated than just being homesick. The move from a family home to a residential setting with a staff team of ten adults clearly challenges children's

sense of where they fit. This appears to conflict with the MBS's therapeutic approach and the sense of 'belonging' as a core concept of the residential work (Diamond, 2015). One part of the school's approach to developing the sense of belonging lies in its use of group work.

5.5 The Mulberry Bush School: Order and the group-work model

The MBS group-work model is core to the school's therapeutic work and is built around both formal and informal group settings, in which all children participate as much as they are able. Before looking at the findings related to this theme, it is first necessary to outline the MBS's use of groups.

Before the MBS, all the children had experienced a period at home, out of school and out of group situations. The children's trauma directly impacted their ability to develop and maintain relationships, which sits at the heart of their inability to make use of group situations. For many of the children, when working and living away from their peers, their behaviours are less extreme, dangerous and difficult – a fact highlighted by all of the staff team and management interviews. However, the school aims to enable children to function as part of a range of groups to prepare them for reintegration into families, education and society (Turberville, 2018). Many of these group situations focus on children living and learning alongside one another, with the support of mature adults (Diamond, 2009), to name the dynamics and feelings in the group. Extracts from my field notes highlight this work:

I joined Jamie's residential house, at his invitation, on Tuesday afternoon after school. The children were all brought back to the house by staff from the classroom and brought into the kitchen, where therapeutic care practitioners sat waiting for them, with a jug of juice and cups for everyone sitting on the table and a plate of cut-up fruit. The children were asked to sit around the table, which they initially did. As classroom staff left, the residential staff asked the children about their day, what had gone well, what had been difficult. Although the group were sat around the table, the discussions were very much individual child to adult and adult to group; there was minimal discussion between any of the children. Within minutes of starting, one child

became cross, swearing and throwing her drink over the table. Staff named that she often found it hard to be alongside her peers, which appeared to incense her. She jumped up, pushing her chair over, and stormed out of the room, followed by a female member of staff (...) five minutes later she rejoined the group, sitting alongside the female staff member, almost as if nothing had happened. The staff member thanked her for rejoining the group, while the others carried on talking to adults; none of the children seemed bothered by the other child's behaviour (...) multiple times children exhibited behaviours, rocking on their chair, throwing something, sliding from their chair onto the floor, etc., to disrupt either the meeting or their own participation in this. Many of these were ignored by staff, but often staff named the behaviour, such as: 'I wonder whether it feels easier to be on the floor than part of the group?' Staff must have used the word 'group' at least 30 times.

Jamie was able to say he'd had a difficult morning and lunchtime, where he'd not been able to eat with the other children, and he'd spent much of lunchtime sat near the top of the climbing pyramid on the front field (...) However, he recognised that he'd had a better afternoon working one-on-one with Andrew [teaching assistant] in class (...) his conversation was directed at the adult, seemingly cut off from the other children (...) Most of the children needed input from staff sat alongside them to sit and listen and to reflect upon their day; even though the informal get-together was less than ten minutes long, this seemed an unbearable amount of time for some of them to be together. As the children left to engage with activities, they all seemed to go in different directions; none of the children left with another child or seemed to want to be with another child.

During the data collection process, I was not able to observe the formal group work, as it was considered to be too disruptive. However, a separate interview with Loraine, one of the group facilitators, gave an insight into how these worked:

We only have four children in the group on a Wednesday afternoon, and sometimes they struggle to stay in the group so are supported by another adult outside the room (...) The group only meets once a week, on a Wednesday afternoon in the music room, and is led by myself and Jo [both staff are therapeutic childcare practitioners] (...) the aim really is to help the child be in a group with other children, which they all find really hard (...) we play co-operative games, and each group is made up of children who we think can benefit from that particular group (...) we only meet for 45 minutes, but that can feel a really long time for the children, and staff (...) I think there are four groups happening at the same time. I don't know much about the other groups, though the facilitators meet each term for supervision with James (...) we both run the group together and have another adult outside the room, so if one of the children needs to be taken out and supported, they can be without it stopping the group (...) I think our group has been going for about eight months now and you can see that they are more able to be in the room together and do an activity together; at first it was awful, they refused to come in or stay (...) when we do the activities we explain to the children what we think is happening, that something might be scary or

worrying but that the others might feel the same (...) sometimes I tell the children that I feel anxious or worried, so they can understand they're not the only one feeling that way (...) it's a very slow process and changes every week depending on how each child is feeling at the moment.

One of the most surprising findings was that very few of the children, staff or families referred to the school's group-work model. Initially, none of the children or families spoke about the child being in group settings until I asked explicitly. The staff made a distinction between formal group-work sessions and the day-to-day groups, such as class groups and living together. This appeared at odds with the literature from the school, the management's views and my observations of the children, which emphasised the use of group work as a central model of the therapeutic milieu:

The main emphasis is on living together, not just in a group but as a group, for the experience of the children, with the help of the grown-ups who also live alongside them. (Chair of trustees)

Interviews about children's early experiences of the school identified a lack of understanding of the group-work model and the distinction between formal and day-to-day groups. When this was highlighted, some participants recognised that the child was part of various groups, such as living together, though this was not true for everybody and was certainly not understood as part of the group-work model:

I'm not in any groups, I don't think. (Leo)

He might be in a group, but not that I've heard of; he doesn't really like being in class and stuff like that. (Leo's mother)

Neither Lola nor her family or staff team were clear whether she was in a formal group-work setting, despite this being documented in her file and confirmed by the group facilitator. This narrative was also apparent for the other families, suggesting either a lack of valuing or understanding group work (or both). If group work is a central component of the MBS's therapeutic approach, it is interesting that families, who are an essential part of the

therapeutic model, are unaware of it. It is perhaps less surprising that the children aren't aware, given their age, but it is noteworthy that not all staff are aware. This, again, suggests a divergence between how group work is described within the therapeutic approach and how it is operationalised.

Some observations further identified this issue. One afternoon, when staff members were taking children from the house to a range of groups and activities, a newer member of staff asked two of the children which room they needed to be in for group work. One child said they 'did not know' and one said they were 'not in a group'. Both had been in these weekly group spaces for at least four months. During a different observation, I watched Leo tell a member of staff that there was not always an after-school group meeting – only when certain members of staff worked – despite groups having happened every day, at the same time, throughout his placement at the school. Perhaps Leo genuinely did not know, but this again appears in contrast to the idea that group work is key to the therapeutic approach. This also suggests a limited sense of involvement in the group model, posing a challenge to Haigh's (2013) idea that 'involvement' is one of the critical elements of a therapeutic approach.

A further aspect of how participants talked about group work is that the children faced difficulties being part of any group, formal and informal. Much of this data came from staff and families: the children found it difficult to talk about being in groups and wanted to move on to a different topic. The ability to be a part of any group setting seemed dependent not only on the individual child but, unsurprisingly, on their experience of the rest of the group. For example, staff working in the residential group with Jamie commented:

He sort of functioned superficially as part of the group, but I think our Rainbow Group at that time managed fairly superficially to function as a group.

While this example relates to Jamie in the formal group, the data provided multiple examples of children finding the informal, day-to-day group settings equally difficult, often resorting to behaviour which led to removal:

As I arrived in the house, the children were moving from different areas of the house to the kitchen for tea. Of the seven children, two couldn't manage this transition, including Leo. Both became verbally defiant and louder towards staff, Leo demanding to be allowed to be in his room and trying to physically push past staff to go upstairs. Staff reminded him that shortly before he had complained of being hungry and asking when tea was. Staff, calmly, pointed out that he often avoided the mealtimes and group times and wondered aloud whether Leo found being in the group difficult. Leo refused this explanation of his behaviour, though did change to agreeing he didn't want to be with the group, but placed the blame on this for another child stating, 'I hate eating with her, she's like a baby.' (Extract from field notes)

There was a particularly strong view that some of the children, while physically able to be in a group setting, were emotionally unable to participate and contribute. This inability relates directly to a critical aspect of the MBS's work, whereby the focus is to prepare the children emotionally for experiences, including groups; it also links to the core research question relating to children's capacity to understand their feelings and behaviour:

She didn't offer anything for a few weeks to the group. She often covered her ears and just seemed to sit there. (Female therapeutic care practitioner working with Lola)

This idea of being physically yet not emotionally present was noticeable in the observations. For example, a male therapeutic childcare practitioner from Kerry's residential house identified that while she presented in a socially acceptable manner, her emotional experiences were often masked. In my observation, I noted the following:

Throughout my short time in the house, I noticed Kerry sitting in the group of children and managing herself,²⁹ despite other children's difficult behaviour and one child running out. Despite seeing her sat nicely, cross-legged and sat upright, I was left questioning how engaged she was, or how much she felt part of that group (...) she only spoke to the adult next to her and seemed oblivious to what else was happening in the group. (Extract from field notes)

²⁹ Within the MBS, 'managing' refers to a child who is behaving in a socially acceptable manner.

For several children, disruption from other children was a factor in their ability to tolerate staying in a group. This was also linked to reasons for their placement, as some children had previously been drawn to others' chaotic and uncontained behaviours as a way of avoiding their own emotional responses:

[W]e see a pretty consistent pattern in that the more chaotic, disordered and unsettled the group feels, the more settled Jamie is within it, and the more settled and engaged the group is and cohesive, the more likely Jamie is to be the one to disrupt that (...) he certainly gets something from the group. (Jamie's teacher)

Both class and residential staff reported a clear pattern of other children's behaviour impacting on the children in this study. For example, a male therapeutic care practitioner working with Kerry said:

Kerry quite naturally got, not forgotten, but she was the managing one. And we had lots of very, very unmanaging children, and she never really complained about it. This seemed to meet a certain need of hers to be present but lost in the group.

However, Leo's and Lola's experiences differed: both reverted to behaviours which either led them to be removed from the group or to remove themselves. There appeared to be a link between the child being able to remain in the group with other children and the quality of the relationship between the child and adult. Staff commented that when the relationship between them and a child was not strong, the child was more likely to leave the group. This also linked to a narrative from some members of staff about their anxiety in being part of, or having to lead, a group; some felt confident and recognised this as an important part of their role, while others appeared to almost 'dread daily groups', feeling this was often where the difficulties were located. This correlates with my observations of children in group situations: the stronger the child–adult relationship, the more emotionally contained the child appeared. This meant that the child was able to tolerate what was occurring within the group setting:

I noticed Jamie come into the school dining room today for lunch, despite the room seeming relatively noisy, with two other children appearing to find the large space very uncontainable. Jamie was with his keyworker and appeared able to ignore the other children and find a seat in the corner to sit and engage in discussion with his

keyworker. This was completely different from the other week when he came with the new GAP student and ultimately left the space in a loud and chaotic manner. (Extract from field notes)

The interviews further highlighted that some children felt emotionally safer with adults than with children. For example, when talking about Leo, a male therapeutic care practitioner said:

What strikes me is that I think he finds child groups more threatening than adult groups, which I find absolutely bizarre given the family history he has been able to share in the group (...) he seems to be really trusting of adults and adult intentions and uses his adult relationships very well, very positively. Yet his relationship with peers seems to hold all of his anxiety, all of the threat.

This apparent anxiety with peer relationships may have been linked to Leo's experience of his siblings, who are older and were described by his mother as having a 'parent-like' relationship with him. Staff interviews highlighted that, although emotional intensity can be greater on a one-to-one basis, children and staff seek out individual opportunities as a way to avoid group space. There was also considerable anxiety among some staff members about using the group to discuss the children's feelings, and about whether staff would be able to contain these feelings and their anxieties should they be allowed to come to the surface.

Over time, participants described a noticeable development in the children's ability to engage with group experiences. However, all the children continued to find groups anxiety-provoking, often needing to leave the group or reverting to behaviours which impacted the running of the group. This was highlighted by a member of the residential team working with Kerry:

[I]n terms of being in a group, she functions, but any pressure, she falls apart, I feel. I think the Pictionary game that we played, she heard something. She drew the right picture, but what she drew wasn't indicative of what actually the word was that she needed to write. It was right there, and Matt was going, 'Well, it's just there. You just

need to put an arrow towards it.' She just goes, 'Ah fine. I can't. Ah, ah, it doesn't matter. I don't want to. I don't care.'

Although this was a subtle example from Kerry, for other children, the behavioural aspect was more pronounced and identified by staff members in both residential and class settings:

I think Jamie found it easier to set other children off, rather than to act out himself. So, he would do things or say things that were quite small and quite subtle and wouldn't necessarily be picked up on. But they would have an effect that would lead to other children in the group acting out and disrupting the group. (Teaching assistant working with Jamie)

5.5.1 *Group size*

As highlighted in chapter four, each of the children had failed to participate and learn in their previous educational placements. Attempts to provide an individualised education programme to the children had also failed, which in part led to their placements at the MBS. There was documentary evidence that this was partly due to the size of groups the children were expected to work in. The MBS's small class groups allow for a focus on the emotional needs of each child, in conjunction with the resilience of the staff:

The smaller group has certainly helped [Lola] settle (...) as she has become more confident and more trusting of both the adult group and the child group, that the child group are safe enough to be around and the adult group are robust enough to hold her in mind; she has found more of a voice. (Female teaching assistant working with Lola)

The consideration of group size applied to all the children in the study. Most of the class and residential groups have six or seven children, giving an insight into the level of difficulty experienced by the children:

It's large groups of children he hates (...) I find that obviously depending on the mixture of children, but I think typically the larger the group, the more negative and difficult he will be within that group (...) he is more likely to initiate a reaction from other children probably to get *them* withdrawn from a group. He wants to be part of a group. I believe he wants to be there, but he struggles with other people being there with him. (Male therapeutic childcare practitioner working with Leo)

Before one of the weekly assemblies, Leo appeared calm and settled at his desk, with two other children nearby:

Leo walked calmly into the sports hall, where around a dozen other children were sat with members of staff. Before even sitting down, he began to look agitated and became rude to children and staff. This led to him refusing to sit and being supported by staff before quickly (2–3 mins), leaving the hall with his keyworker. Outside the hall I could hear Leo becoming louder and louder, demanding to be let back in to the assembly. I spoke to his teacher afterwards, who said, ‘He hates large groups, but hates missing them as well.’ (Extract from field notes)

The struggle to be in a group, yet to remain emotionally detached from the group, was identified several times by staff and through my observations, but never by parents. This may reflect the smaller group size of a family environment, which may feel less threatening to the children, or it may suggest that the therapeutic nature of the MBS’s group-work model feels less intense than the home environment. This question was specifically addressed to each of the children during their final interview. Both Kerry and Leo found this difficult to think about; they suggested that they were ‘fine in groups’. Lola recognised that ‘sometimes I like to be on my own’, and Jamie showed the most insight, identifying that he ‘doesn’t always like being in the group’ but that he ‘didn’t like missing out’. This was a significant recognition from Jamie, and to a lesser degree Lola, and could correlate with Jamie’s move towards emotional self-management.

5.6 Children’s progress towards emotional self-management and personal relationships

One of the most prominent findings of this research was the sense of progress made by the children throughout their placements, supporting evidence from other research undertaken within the MBS and discussed in chapter two (Gutman et al., 2018; Harriss, Moli, et al., 2008; Price et al., 2017). All interviews identified numerous areas of progress: behavioural, academic, emotional, the ability to recognise feelings, the relationship between emotions

and behaviour, and the ability to be alongside others – for example, in group settings.

The children identified that they increasingly liked being with other children, and did not formally recognise these as group spaces. They identified class and house groups, which they found more enjoyable as their placement progressed:

Interviewer: Has being with other children helped you?

Jamie: Definitely, 10 out of 10, it's much better now. I don't get taken out of the meeting or the mealtimes anymore. Other children do, but I don't.

All participants identified progress in the children's behavioural difficulties, closely aligned to their experiences of being at the MBS, with its focus on determining how feelings lead to behaviours. Parents and staff discussed how the school's approach differed from that of previous schools, as staff focussed on understanding the link between feelings and behaviour, rather than just preventing certain behaviours:

He's not getting angry so quickly. He's also now aware that I'm here to help him to get him out of situations, rather than seeing me as someone who is just saying 'no' to him. He knows that I'm actually trying to help him so that he doesn't lose it. So, that's ever since he's come to the Mulberry Bush. (Jamie's mother)

This increased ability to remain within a group was noticed by teaching staff and parents to correspond with the children's ability to engage in the classroom activity:

Initially, she used to leave groups, she used to get up and walk out of groups, but this didn't happen very often. Fairly soon, she was able to stay in the group without being disruptive and could tolerate the group. (Lola's teacher)

Staff, parents and children all highlighted that the children's attitude towards learning had significantly developed, evidenced by their ability to remain within the classroom and engage in learning activities:

She would refuse point blank: 'I'm not picking up the pen. No. My handwriting is messy. Not even touching it. You'll take the mickey out of my spelling,' and now it's a case of, 'Mum, read my story. Mum read this. Mum read that. Mum read this. Mum look at what I've done. Mum.' It's more, 'Because I get to learn new things (...) I love school.' (Kerry's mother)

You know, his academic work is much, much better. He's actually doing it now (...) I think the much smaller classes, the teacher who knows how to deal with children who've got emotional and behavioural difficulties is definitely an advantage. (Jamie's mother)

Consistently, parents identified that children functioned much better within their family settings, but they were unable to comment on how their child was in MBS group settings. When children returned home during school holidays, parents noticed significant progress in their child's behaviour and ability to be part of the family group:

When he's come home, I've seen that he is generally at a calmer level. If he's at a calmer level, he's not going to fly off the handle as quickly. I think this has had a calming influence on him. I think he's enjoying it here, I think he's happy here [at the MBS], and I don't think he's been happy anywhere for a very long time. So, I think the fact that he's happy, he's content, he's stress-free, he's not having all that stress of completely losing it frequently, is having a very good effect on his mental well-being. (Jamie's mother)

For Lola's foster mother, the progress has been noticeable in their daily interactions:

[W]hen she was really angry, and it might be over something just simple, like brushing her hair, and she'd say, 'I hate you. You're a horrible lady.' She'd be streaming with tears, and she'd be so choked up. She could hardly speak. She was so cross. She'd run up the garden away from me, so she didn't have to have her hair brushed, but now, I say, 'Right. Grit your teeth.' [Laughter] We're winning all the time. It's a win-win. She just stands there, and I brush it through.

This increased ability to be part of wider groups was also noticeable in relation to home life:

I think his relationship with his mum has, although was always strong, and his relationship with his family was always strong, I think it has become much stronger, with not just his immediate family, but with his extended family. I think he has invested; he understands that people can care about him, and that he can care back and that it is okay. There is definitely a difference there. (Male therapeutic childcare practitioner working with Leo)

Leo's mother described home life as 'much better' and identified that Leo:

listens a lot more to everything (...) there's no flying off the handle, there's no shouting (...) Like I say, I think it all comes back to his understanding of things, and he's more independent.

All parents referred to their child's increased happiness since the start of the placement. This was captured emotionally by Jamie's mother:

[I]t's the first time we've actually seen him happy, possibly ever, actually.

5.6.1 The building of relationships

This development of the children's relationships was described by Kerry's mother when discussing her partner's role in the family:

She even gave you a Father's Day card last year. Whereas it was totally, 'This is my mum, my siblings, you're not allowed near them. You're not allowed near Mum. This is my mum.' But now it's a case of, 'Dad, do you fancy playing a bit of footie in the back garden? Dad, can you do this?' It's not solely me. It's, 'Oh Natalie, do you fancy playing skipping?' She's more bouncing off all the people in the family.

The children also reported that relationships at home improved, recognising some of the previous difficulties and showing an awareness of their current family situation:

Yes, I argued with my sister all the time and fought, but now we get on all right in the holidays. (Kerry)

With the exception of Kerry's mother, all parents were able to identify one or two friendships that their child had formed in the local community, including play dates. The children themselves indicated that they had lots of friends and good relationships with peers and adults at home. This contrasted with the views of staff, who highlighted that within the MBS, children continued to have significant difficulties with peer relationships. These often led to

children isolating themselves from peers or becoming overly dependent on adult relationships. Discussing Lola, one female therapeutic childcare practitioner commented:

[W]hen more than one child comes into the situation she very quickly withdraws. You can see her sloping to the edge of the group. So, for example, if we've got the Polly Pockets [toy] out in the lounge, and she's happily playing with me and another child, then if a third child comes in she will slowly edge away. She'll nip and get a teddy bear, come back to the room but not with the play and really just edges out, whereas when she first arrived, she would take herself to her room.

5.6.2 Behaviour

The impact on families was discussed earlier, but all parents were able to identify multiple examples of extreme behaviour, particularly aggression. All parents recognised, soon after the start of the placement, an improvement in behaviour, and were able to realise that the changes in behaviour were far more significant than just a reduction in intensity and frequency of physical aggression. These changes seemed directly linked to the children being more aware of their feelings:

I think a couple of weeks ago she got really annoyed to the point where she kicked another hole in the wall. But it wasn't a case of, 'I've kicked it and hahaha.' It was, 'I've taken it too far. Please leave me be. I need five minutes to calm myself down.' It was totally different from before. (Kerry's mum)

Parents were able to recognise improvements in behaviour not only at the school, via reports, visits and phone calls, but more importantly in the home environment. The children identified that they 'had a lot less incidents, and I am able to tell some people how I'm feeling' (Lola), and this was supported by the views of parents:

[S]he got more coping skills to level herself out, I'd say. If one of them is, I don't know, getting a bit upset or moody because they've got to sit in the car, she'll realise, 'Okay, I'm not going to, I'll try and play a game. I won't try and feel annoyed' (...) but you can also let her take herself away, and she'll come back five minutes later: 'I realised I done wrong. I apologise.' (Kerry's mother)

Parents spoke about the quality of communication – for example, how the children were able to tell them about difficulties they had experienced at school since they had last spoken. At the start of the placement, parents felt they relied upon staff to keep them up to date with their child's behaviour, but as the placements progressed, their children were able to tell them directly when things had been difficult and reasons why:

Then, the next day, he'll ring, and it will be like, 'Oh, yes, well, I was missing home,' 'This and that happened,' or whatever. (Leo's mother)

The links between feelings and behaviour were noted throughout the data collection, but there was a strong narrative for the parents, particularly for the foster and adoptive parents, of being mindful of the messages they gave to their children. For instance, Jamie's mother said:

[W]e didn't want to say to him, 'We've sent you away because of your bad behaviour.' That was not the message that we wanted to give him.

The parents' sense of protecting the child by not rejecting them appeared to contrast with the children's views of themselves. All the children were more practical, seeing their placement and behaviour as directly related. For example, Leo described his previous placement, at which he'd been physically aggressive to other children and staff, by saying, 'They just excluded me, I didn't do much. It wasn't the right school for me anyway.' Jamie and Lola showed more denial or disconnection, and a purely factual understanding. For example, Jamie said:

They told me nothing actually (...) No, they told me I was coming here, but they didn't tell me why.

When questioned about why he was placed at the MBS, Jamie responded, 'I got excluded, but it wasn't my fault' – a similar response to Leo and Lola when discussing their previous school placements.

An unexpected observation was identified by Leo's mother. When asked about other behavioural changes she had identified, she said:

[W]hen he got stressed before I could see him changing, he would get redder in his face (...) his breathing was faster and stuff like that (...) that doesn't happen so much now.

Thus, the data from the interviews is supported by the literature, highlighting that children make good progress at the school. What is particularly significant about this research is the voice of the children recognising their levels of progress towards self-management.

5.7 Where is the 'therapeutic'?

While the other themes in this chapter were identified through the gathered data, this theme feels noticeably different, yet equally, if not more, important. The word 'therapeutic' is noticeably absent from interviews with the children and families, neither of whom made any direct reference to the therapeutic nature of the school, and also from interviews with many of the staff. This seems significant, relating directly to the MBS's therapeutic approach and this study's central question.

Although referral documentation referred to the MBS as a therapeutic school, it was difficult to gauge the level of understanding among participants from the data. Where there was a direct link between the child's traumatic background and the referral to a 'therapeutic boarding school', this was in the documentation from psychologists and therapists.

The literature review in chapter two identified confusion over the term 'therapeutic childcare', and families appeared to share in this confusion about the therapeutic nature of the MBS:

I don't think we were quite sure about what it meant, no. I didn't really know what it meant to be honest. We did some research on the school. We were looking on the websites, we visited here, to try and get a feel of it. That's before it had been decided

whether the funding was available. I don't think we had a very clear understanding of what a therapeutic school was, or what that involved. (Jamie's mother)

Because it's quite a tricky place to describe. Yes, they kind of tell you, 'This is what we do,' but I think until she was actually there, and you could actually see what was. Then they would have meetings, and they would explain what they've done, what they're doing. I think you can't really understand it until they're actually there. (Kerry's mother)

For some parents, the word 'therapeutic' referred to direct provision from a specialised therapist, rather than to the 24-hour-a-day therapeutic milieu which the school provides:

Well, I've been told that the therapy will come after her initial time, 12 weeks or whatever, and then they'll see what therapy, if she needs it, is there for her then. Music, drama, all these sorts of things. (Lola's foster mother)

Leo's mother was also unsure of the therapeutic input at the MBS, but described her son's previous school:

The last school: they had a therapeutic room, where they had waterbeds, 'touchy-feely', and an open-air heated swimming pool. It was actually the best thing you'd ever seen on the grounds. It was absolutely beautiful. Leo was quite pampered. Leo was quite spoilt there, to be honest, to the extent of the foot massages and the oil rubs.

While it may be unsurprising that parents do not have a comprehensive understanding of the therapeutic approach, this appears to contradict the earlier discussion about the role parental engagement has in positive outcomes (Browner and Onions, 2014). If parental involvement is core to the MBS's approach, this appears to be compromised if parents have limited understanding of the school's work.

The comments from Leo's and Lola's parents appear to suggest what was expected by the term 'therapeutic' at the MBS. Previous experiences and placements had involved a set number of sessions with a therapist for each of the children. These had typically been

provided by external services, such as CAMHS, and were brought into schools or therapy centres.

This impression differed from that of the staff, who mostly seemed clearer about the therapeutic milieu on which the school is based. However, this differed between the care and education staff teams, with education staff making more reference to children 'attending therapy', despite the therapeutic milieu overarching the entire day. Again, this suggests a split between these two staff teams, and given the previously discussed split relating to experiencing the emotional intensity of the work, it suggests a lack of shared understanding of the therapeutic approach. This may be another example of unconscious defence, but is more likely to represent a greater focus from the education team on the task of 'educating'. Regardless of the underlying reason, it again suggests what Klein referred to as a 'split' in understanding and using the therapeutic approach (Klein, 1992).

5.8 Summary

The findings presented within this chapter highlight the rich and diverse narratives pertaining to the research questions. As such, they help to develop an understanding of the children's experiences while placed at the MBS.

The initial analysis of the data identified a more comprehensive range of emergent themes, many of which were particular to individual children. These included topics such as professional perceptions of children and the effect of multiple placement breakdowns. The five themes³⁰ presented in this chapter revealed a greater degree of similarity between the

³⁰ The interconnections between children's feelings, behaviours and relationships; how behavioural changes are viewed and understood; how the model of group work is understood; the emotional impact of working alongside children who have experienced trauma; and the wide range of expectations from children, staff, families and professionals about children's progress.

children's experiences and backgrounds than had initially been envisaged. Of these themes, many of the responses correlated with the findings of previous MBS research (Gutman *et al.*, 2018; Onions, 2017a; Price *et al.*, 2018). This was particularly true concerning children's progress, but also to a lesser degree the self-awareness of their own feelings.

However, several crucial issues have been identified within this chapter which are not found in the literature, suggesting that further analysis and research are required beyond this study. These include:

- The lack of understanding and awareness of the group-work model, which is central to the MBS's practice. Although not fully anticipated, it does correlate to the research undertaken with MBS families (Onions, 2017a).
- The limited reference to and understanding of the 'therapeutic' nature of the school, again something which is central to the school's practice.
- The lack of support from professionals felt by parents, and some staff, when dealing with extreme emotional impact.
- The consideration of what supports children to build healthy relationships and whether this is impacted by their family background, including whether male (father) figures have been present.
- The understanding of peer relationships and how children develop and understand relationships with staff and families.
- How children's unconscious defences, such as splitting, impact the close working relationships between team and families which underpin the MBS approach.

These issues link to a theme of 'misunderstanding', whether referring to behaviours, ways of working, intentions or relationships. These issues are critically analysed and discussed in the

following chapter. They are presented with specific reference to the earlier literature review and the theoretical framework, as set out in chapter two.

Chapter Six: Analysis of findings

The central question for this study is how the therapeutic approach of the MBS affects the children in its care and their relationships. This chapter commences by exploring the complexities inherent in understanding the nature of therapeutic work and, more importantly, the impact upon the children. Special attention is paid to how the school's therapeutic approach affects the children's understanding of their feelings and the impact of this on their relationships and behaviour. This is followed by an exploration of how the MBS's group-work model is understood, and how it affects the children, before considering the emotional impact of working with children who have suffered trauma in their early lives, as understood by the children, their families and MBS staff. Finally, I explore the impact of placement objectives on the therapeutic work with each child.

My analysis draws on theoretical frameworks presented in chapter two – in particular, psychodynamic theory, reflective practice and psychosocial theory. As discussed in chapter two, psychodynamic theory builds upon Freud's view that we should attempt to make sense of unconscious processes – those we may not be aware of and cannot consciously control – and, therefore, some of the evidence I seek to interpret includes the unconscious communication of both the research participants and myself. By addressing these unconscious dynamics, a deeper level of understanding is achieved (Jervis, 2009). This makes use of the best evidence available but recognises that the nature of the case and evidence leaves some room for alternative interpretations. The concept of the unconscious is complex and, at times, controversial, with questions about its nature and its relation to individuals' consciousness. Despite the field of psychoanalytic work having a long, well-established history, any claim resting on appeals to the unconscious can, perhaps, never be more than plausible interpretations of the given evidence, despite whatever illumination and explanatory power the suggestions display.

The idea of recognising feelings as part of a therapeutic process is used throughout this study to provide an insight into the findings and the most plausible interpretation given the available evidence (Kvale, 1999). The issue of reflexivity, discussed in chapter three, recognises a potential limit on the authority of any interpretation, including my own (Ward, 2006). Bion recognised his inability to define and understand unconscious processes, referring to an 'unknowable central abstraction' (1963) when discussing containment, a concept that is central to the therapeutic task (Haigh, 2013).

I have sought to identify and explore multiple perspectives to understand the effect of the therapeutic environment offered by the MBS.

6.1 Understanding the therapeutic model

There is an academic consensus for the need to define the term 'therapeutic' (Gallagher and Green, 2013; Whittaker *et al.*, 2015), and while Whittaker *et al.* (2015) have tried to advance definitional agreement, a lack of clarity remains. In this chapter, the lack of reference to the 'therapeutic approach' reflects the confusion around this definition and is directly related to the lack of understanding of the school's therapeutic approach. It is this lack of understanding, rather than the broader academic concept of 'therapeutic', that I am concerned with. Nevertheless, if, collectively, we are unclear about the concept of 'therapeutic', then it is unsurprising that individuals within the MBS experience difficulties articulating a working therapeutic model.

As chapter four discussed, the MBS situates itself as a therapeutic environment/milieu, allowing children to develop a sense of safety, to make sense of their emotional experiences and relationships (Diamond, 2005). The literature frequently discusses the school's therapeutic model (Diamond, 2013; Dockar-Drysdale, 1968, 1973), particularly the emphasis

on relationships, the psychodynamic underpinning and the need to understand behaviour as a communication of need. However, evidence of the therapeutic approach appears lacking, particularly regarding staff focus groups. One way of understanding this difference is to suggest that it may not purely be due to a lack of understanding of the school's model, but, as the evidence suggests, it may be due to the need to maintain a defence mechanism, keeping an emotional distance between children, families, staff and management. The school's therapeutic model is relationship-based (Diamond, 2004; Turberville, 2018), yet the intensity of maintaining relationships and remaining emotionally in touch with the children's traumatic feelings can, for some, necessitate an unconscious drive to maintain an emotional distance (Ward and McMahon, 1998). The school uses a model of reflective practice to try and bridge this unconscious response, but this is dependent on individuals being emotionally resilient and open to reflective practice (Farrell, 2012) – for example, comparatively, staff who were forthcoming about joining the research focus groups and those who showed ambivalence about joining.

For some, particularly the children, a limited understanding of the therapeutic approach is appropriate. However, for staff, and to a lesser degree families, this limited understanding could be viewed as more than 'not knowing', but as an emotional defence. As chapter two acknowledged, emotional defences can be unconsciously used to protect against the impact of trauma. Thus, rather than 'misunderstanding' or 'not knowing', there is perhaps 'emotional avoidance'. It was clear from staff in the focus groups that a therapeutic paradox existed. The therapeutic approach is based on safe and containing relationships, yet the closer the therapeutic relationship, the more attuned the participants are to the child's emotional trauma. As such, the lack of understanding may serve as a psychological defence against facing the trauma's emotional pain, as discussed by Klein (2011), who suggested that early-life traumas remain in the unconscious and give rise to individual defences to avoid them resurfacing.

The idea of defending against resurfacing trauma is not isolated purely to the children, and consideration should be given to whether the families have experienced their own trauma (Cook *et al.*, 2005), either directly or through the child's trauma. For example, Leo's life experiences were traumatic for him and also led to vicarious/secondary trauma (Pearlman and Saakvitne, 1995) for his family. This led to his mother describing the family as being 'at breaking point', desperate for the MBS placement, without being clear about what it involved or even the school's geographical location. The evidence indicates the intense pressure experienced by the families, and their difficulties in relating the children's traumatic experiences for the required therapeutic placement. Both Kerry's and Leo's mothers recognised that the work had been explained to them, but that they had not thought about or understood it. They may have been emotionally unavailable to new information, unconsciously resisting taking anything else on. This idea of unconscious resistance reflects what Haigh (2013) described as the 'dragging in' of material which individuals would rather ignore – in essence, the expectations of the therapeutic task are painful for all involved and so are avoided at an unconscious level. This reflects the emotional intensity of living with the children and the unconscious expression of 'just make them better', recognising, painfully, the need for a therapeutic setting. This matched comments by T&NT members, who spoke about how their work enables families to become more consciously aware of family dynamics and the impact the children's early-life trauma had on the wider family.

However, despite the evidence suggesting some level of emotional defence, it is noteworthy that the lack of clarity about the term 'therapeutic' links to chapter two's recognition that the literature surrounding therapeutic childcare is also unclear. It may not be surprising that staff and families are unclear when the literature is also unclear. However, the therapeutic model of the MBS is more clearly, though not always explicitly, defined. Thus, the lack of understanding may be a combination of the above factors.

Some participants – principally management and trustees, who were among the most forthcoming staff – stated that the school has a clear therapeutic model articulated through its training programme, practice and written documentation. However, this view contrasted with the limited understanding of the families and children. This is not to say the therapeutic model is unclear, but it is not always understood by participants or articulated by the MBS in a manner that supports understanding. As chapter five discussed, this was not explicitly raised in interviews, although it featured in the documentation for each child. This relates to the issue of families feeling a divide between themselves and professional networks.

Families and carers made no mention of professionals explaining why a therapeutic placement was sought before their child arrived at the MBS, or what this might involve. This reflects not only the perceived lack of support from professionals, but also a lack of understanding by professionals of the children's placement needs (Stanley *et al.*, 2005). This view is supported by some of the documentary evidence relating to the four children, in the form of reports and recommendations written by professionals.

This limited professional understanding of the work relates to the anxiety professionals may experience when managing complex cases and placements (Mosuro *et al.*, 2014). There is significant pressure on local authorities to place out-of-school children, many of whom have experienced trauma. This pressure can cloud the judgement and understanding of placing professionals while they seek to meet their statutory responsibilities to provide suitable education (Department for Education, 2017). This suggests that the MBS's core principle of 'collaborative working' is difficult to implement when working systemically. While staff recognised Richardson's (2003) description of the systemic need for 'interconnected parts which affect one another', this was predominantly discussed in relation to internal dynamics and working with families. Only the T&NT staff referred to working with professionals and suggested that the MBS's collaborative approach (Turberville, 2018) may need greater articulation and understanding within the MBS.

The lack of reference among the staff to the terms ‘therapeutic’ or ‘collaborative working’ was striking and reflected not only a lack of understanding but a lack of confidence, expressed through confusion, in implementing the model on a day-to-day basis. Returning to the audio transcripts, it was clear that those who discussed the terms more were the senior staff, suggesting that newer or less senior staff have less confidence, or understanding, in discussing the therapeutic model. Psychodynamically, this mirrors the confusion surrounding children’s backgrounds or a denial of acknowledging the high level of emotional trauma which children project onto the staff teams. Both of these would explain why more senior staff, who were generally more distant from direct work with children and families, were confident in their understanding of the therapeutic model, matching the organisational issues discussed by Menzies Lyth (1988).

An alternative understanding would be that the term ‘therapeutic’ represents a much broader range of practice models, rather than the more specific models identified in chapter two – a view supported by Haigh (2013). Participants clearly lack a shared understanding, and subsequently expectations, of the therapeutic placement. This suggests the term ‘therapeutic’ is used more broadly by professionals outside the MBS, thus adding to the confusion regarding the term. While this might be anticipated from the children, it could be concerning for adult participants and requires further investigation.

Although there is a lack of confidence and clarity in the school’s model, some elements are clearly understood. Using Haigh’s (2013) identification of the quintessence of a therapeutic approach, the importance of attachments and relationships is evident. Both underpin the therapeutic model (Dockar-Drysdale, 1990; Turberville, 2018) and their existence is supported by the staff, management and trustee participants, all of whom spoke about the focus placed on relationships and about the children’s increasing ability to develop and maintain relationships.

Although it is difficult to tease out what supports good relationships in residential care, a lack of staff training and high turnover does contribute to poor relationships (Hart *et al.*, 2015). This reinforces statements by managers and many of the focus group members, who described the MBS as having low turnover,³¹ emphasising staff training³² and recognising the impact this has on positive relationships for the children. This is further supported by the school's annual staff survey, which indicates staff experience and the school's commitment to their training (Mulberry Bush, 2019).

6.2 From feelings to relationships

In addition to the limited understanding of the term 'therapeutic' within the MBS, there is limited awareness across the childcare sector of how children's emotional needs impact their feelings, behaviour, educational attainment and relationships (Ward and McMahon, 1998). Although Lola's and Jamie's documentation discussed their difficulties with feelings, this did not appear to be the primary reason for their placements; it was predominantly due to aggressive and antisocial behaviour which could not be contained in the home and at school, leading to repeated placement breakdown and thus reflecting the need for a containing environment provided through 'good enough' caregiving (Winnicott, 1965). Thus, the MBS placement reflects the visible behavioural issues which have the greatest impact on others, rather than the underlying emotional content behind the behaviour. Understanding feelings is an essential aspect of working with children who have experienced trauma (Perry, 2007; Ward and McMahon, 1998), those who often experience difficulties in understanding their own feelings and those of others. These difficulties relate to struggles with relationships and subsequently to behaviour. When the child feels emotionally uncontained, they exhibit

³¹ Connor *et al.* (2008) indicate that annual turnover rates of 34% are not uncommon in the USA, whereas the MBS reports a more modest annual rate of 12% (Turberville, 2018).

³² The government requires care staff in England to be trained to a minimum level 3 diploma standard, whereas the MBS trains care and education staff to a minimum level 5 foundation degree.

distress through their behaviours as an unconscious communication of an unmet primary need (Ward and McMahon, 1998), a point consistent with my own findings.

6.2.1 *Sense of self*

Chapter four provided rich accounts of the children's lives and backgrounds, all of which impact their sense of self (Neagu and Sebba, 2019). The children's narratives often differed from those of their families and written documentation, suggesting an overall confusion regarding the children's life events, not just among the children themselves. The increased number of carers and tensions within their relationships contributed to each child having an unclear sense of self.

For both Leo and Kerry, the two children from birth families, the evidence suggested that when first placed at the MBS they presented an artificial portrayal of themselves, or 'a false self' (Winnicott, 1960). Discussing their backgrounds and friendships prior to the MBS, all four children spoke of 'having lots of friends'. This contradicted the views of their families and carers, written reports and the research of Harriss, Moli *et al.* (2008). Although the children described real people, the 'friendships' appeared to be projected as part of a false self, suggesting that, like many children in residential care, their experience of friends was extremely limited (Neagu and Sebba, 2019). A false self may be used to hide not only the lack of friendships, but the underlying difficulty the children experienced with developing and maintaining relationships.

However, findings from the second and third interviews with the children suggested a developing sense of self and an increasing sense of others (Baumeister, 1987). This led to increased awareness of the impact of others and the development of an appropriate sense of self and of vulnerability. This was supported by observations. At the start of the study, all the children chose to remain close to adults, but later observations showed Kerry, Leo and

Lola all playing with other children, though within sight of staff members. This is an example of Bion's (1962) concept of 'container/contained': when a child feels emotionally safe, they can explore their environment and increase the space between themselves and their primary carer. However, Jamie, who showed more transient relationships, was the only adopted child, and he matched the views of Winter and Cohen (2005) that those children with less awareness of their birth families experience greater difficulty in developing their identities.

6.2.2 *Relationships*

The difficulties in developing a sense of self and understanding of others relate to a recurring theme from this study, that negative early-life experiences lead to an inability to develop and maintain relationships. In this context, developing relationships means learning how to relate to others and oneself, and is highlighted within the therapeutic task as essential (Haigh, 2013; Ward and McMahon, 1998). It relates to the children's attachment profiles, highlighting classic examples of 'ambivalent' and 'avoidant' relationships (Ainsworth, 1989). Thus, we see that, without relationships, the MBS's therapeutic approach is limited in its effect on the children.

Using Winnicott's (1986) idea that childhood trauma breaks the continuity of a child's existence, we must consider that the therapeutic task, in part, is to attempt to 'repair' this through providing continuity of relationships. The findings evidence the differences in children's abilities to develop and invest in relationships. For example, staff described Jamie as 'needing intense individual relationships' with females or those he viewed as holding a position of authority – for example, his keyworker and the household manager. However, staff questioned Jamie's ambivalent³³ comments about his relationships; when his female keyworker left, he said, 'Good, I'm glad she left. She was bossy, and I didn't like her.' Staff

³³ In this context, ambivalence is an emotional state of opposing feelings/behaviours towards another individual, object or experience. It can be regarded as a defence (coping) mechanism.

noted to his family, and to a lesser degree Jamie, that when his behaviour subsequently deteriorated, he became aggressive and abusive, especially towards women. This suggests a far stronger relationship had developed than had been acknowledged. The loss reflected the previous maternal losses Jamie had experienced, reinforcing his view that maternal figures always reject him. This, again, matches the research regarding adopted children (Winter and Cohen, 2005). The staff experienced a sense of guilt, indicating a projected defence from Jamie – guilt about building close relationships at the expense of his relationships with his birth and adoptive mothers. This example illustrates Winnicott's (1958) idea that the child's guilt is linked to their tolerance of ambivalence. Jamie has not developed this tolerance, thus is defensive, projecting his unbearable feelings of guilt onto others and resorting to physical aggression or running away: 'fight or flight' (Bion, 1961). Staff reflections reveal potential anxiety over becoming too emotionally involved and in touch with his emotional trauma. Thus, unconsciously, staff created an emotional distance as a defence. Although considered a limitation of the MBS model, in fact it reflects the almost impossible task of maintaining such an emotionally intense relationship.

6.2.3 Family relationships

Many of the children had experienced this emotional intensity within their relationships with families, peers and professionals. For those who have repeatedly moved placement, the ability to develop and maintain safe and trusting relationships is increasingly difficult, yet James (2011) suggests that children in care often experience improved relationships once they experience a stable placement, such as at the MBS.

Despite this, the views of the parents and carers were compelling; their relationships with the children were significantly improving.³⁴ When children returned home for holidays and

³⁴ The term 'improved relationships' was described by parents as less verbal arguing, less physical aggression towards parents and carers and an improved ability to converse.

occasional weekends, they presented as 'happier', 'less worried' and 'much nicer company'. For Leo, Lola and Kerry, evidence suggested that within a few months of commencing their placement, their behaviour while at home hugely improved. One interpretation of this is that the children identified the MBS as a 'safe place' (Bowlby, 1988) or holding environment, somewhere capable of containing their strong emotions and providing emotionally attuned and safe responses. As such, Klein's (2011) emotional defence phenomenon was observed, with children 'splitting' positive experiences at home from less positive ones at the MBS. Despite being a defence, splitting is a developmental step for children who can acknowledge a separation between good and bad objects, people or experiences, as discussed by Rycroft (1995).

This concept was also evidenced by parents, particularly in relation to splitting the emotional impact into the school. Parents recognised that the children's improvements led to improved family relationships and vice versa. Parents, particularly birth parents, found the idea of leaving the emotional trauma within the MBS, or holding environment, much easier. This is another example of 'splitting' (Rycroft, 1995): the need for families to create an emotional split between the school and home.

The example of Jamie's keyworker leaving and his becoming angry and violent is helpful for understanding the impact on his family relationships. One way of accounting for this is to consider Jamie's attachment pattern as an adopted child. As Jamie became more emotionally aware of his feelings and background, he experienced another 'maternal rejection'. Staff identified that it was around this time that he articulated his wish for a relationship with his birth mother. This was at the expense of his relationship with his adoptive parents, almost as if it was unbearable for him to experience the difficulties of 'shared parenting' (Onions, 2017a) between his adoptive parents, birth parents and the MBS. This presents a paradox: working with a child with attachment difficulties leads to a complex 'shared parenting' model. This supports Diamond's (2004) position of the staff

team, rather than individuals, holding the attachment, as a means of emotional safety for the child and staff.

Developing family relationships and the family no longer feeling at 'breaking point' were themes identified throughout the findings, primarily by adults, as well as by Onions (2017). While participants felt children became more trusting of their family relationships, varying interpretations exist. For example, the children's feelings towards others may not necessarily have changed, but their family's and carer's feelings towards them may have. There was a genuine shift in relationships, which became less 'fraught' and 'intense', but also an increased ability for parents and carers to accept the child in the home environment. This, in turn, increased the sense of the 'holding environment' (Winnicott, 1963a).

For all the parents, this was the first time they had experienced their child being away at a residential school, and the first time they had relied on telephone contact rather than face-to-face communication. At the start of the placements, neither Leo nor Kerry were able to engage in discussions over the phone and relied upon their parents asking direct questions during regular calls – something birth mothers particularly experienced as burdensome (Attar-Schwartz, 2019). However, as Leo's and Kerry's relationships developed, changes became apparent. Both became more able to ask how siblings and parents were and to engage in conversation. Staff described how the transference they experienced during phone calls initially indicated high levels of anxiety, anger and guilt – something not identified by the children. This reduced over time as the children engaged more, and even asked to phone, suggesting both their developing relationships and their increasing ability and desire to engage with others.

This idea of guilt has been discussed by a number of authors, including Holmes *et al.* (2018) and Dobel-ober (2005), and is similar to the divided loyalties children in stepfamilies often experience (Baxter and Jack, 2008). Interestingly, both boys expressed ambivalence about

phoning home, though, on reflection, I wondered whether this was actually guilt and avoidance of how painful such phone calls could be. It seemed that, for Leo, the idea of linking home and the MBS was simply unbearable, until he received his family's permission, at an unconscious level, to enjoy the MBS. His family were clearly important, but his responses left me questioning whether he experienced guilt for enjoying himself at the MBS, and projected this due to his inability to tolerate his own ambivalence (Winnicott, 1958). This idea of Leo's guilt was reaffirmed by staff, who highlighted that both Leo and his mother had experienced heightened levels of guilt at the start of his placement.

Winnicott (1953) discusses guilt and its links to loss, which can be attributed to the children being away from home and the shared sense of loss between children and families. It was unclear how much of this loss and homesickness, or 'survivor's guilt' (Holmes *et al.*, 2018), came from the children through transference, and how much came from the families and carers. Both Jamie's and Lola's birth mothers spoke of feeling overwhelmingly 'sad' after speaking to their children on the phone, while both children appeared more ambivalent, representing their ambivalent attachment styles. However, the findings also identify parental guilt, which represents Winnicott's (1971) idea of the 'good enough' parent: the idea that a separation between child and parent is natural and, when planned, allows for positive cognitive development. However, the idea of the good enough parent had not previously been experienced by the children or parents; instead, a series of enmeshed, absent and complicated relationships had existed. This sense of parental guilt appeared to match a more planned separation and development, which was emotionally painful yet developmental and represented a 'loss of control' for parents, again matching the earlier work of Harriss, Moli *et al.* (2008).

Despite the early-life complex trauma and the feeling of being 'not good enough', it is clear that relationships between children and their families are important. The evidence proposes that, for most of the children, their family relationships became stronger and less emotionally

charged as their placement progressed. However, there was some degree of fluctuation that appears, certainly for Jamie, to have been dependent on environmental factors, such as staff leaving. The stability of his relationships at home was dependent on the stability of those he experienced within the MBS. When those at school faltered, he experienced a loss of the 'holding environment' and displayed increased aggression and anger at home.

6.2.4 *Peer-to-peer relationships*

All the children experienced extreme difficulties in forming appropriate peer relationships. As explored in chapter four, this not only represented the disastrous effect their early-life trauma had had on their ability to develop relationships, but it was compounded by their numerous placements (Perry, 2007).

Despite this, the evidence highlighted that each of the children felt they experienced improved peer relationships, though for some these were more transient. For example, both Kerry and Leo identified that they had not had friends before the MBS but now enjoyed each other's company, showing an age-appropriate awareness of other children's difficulties. Kerry spoke about enjoying playtimes with two other children, but this was dependent on their behaviour and she disliked their company when they were 'being dangerous and hurting people'. This represents her need to experience a secure attachment. When her peers and environment provided her with a safe, consistent setting, she engaged and related. This matches Ainsworth's description of the young baby exploring their environment, but only when they first experience safe and reliable emotional holding (1989). Again, this evidences Bowlby's discussion of the need for secure early-life attachments, and the impact when these fail (1988).

These improvements in peer relationships appear to contradict aspects of the existing research (Bolger *et al.*, 1998), suggesting that the type of early-life complex trauma is not a

clear factor in the child's ability to develop peer relationships. This difference represents the effect of the therapeutic approach and the emphasis on relationships compared to research carried out in other settings.

This idea of developing a secure attachment was evident in relation to Lola, whose peer relationships shifted significantly throughout the interviews. Initially, she described herself as having no friends, only trusting and feeling safe with a series of hand puppets, through which she conducted herself during her first interview. This further represents Winnicott's idea of the 'false self' (1965): Lola resorted to a defensive façade to hide a sense of emptiness. By talking about the puppets' feelings, she seemingly avoided having to acknowledge her own, or her lack of awareness of them. This corresponded with staff comments, certainly matching the descriptions given by Ainsworth (Main and Solomon, 1990) of children with attachment disorders, and Dockar-Drysdale's (1990) writings about 'the frozen child'. However, by the final interview, Lola was able not only to name friends, but verbally and through her drawings to reference herself with consistent peers, whose names staff corroborated when interviewed. This is an example of how the MBS affected Lola, supporting her to understand her feelings and how she related to others, enabling her to develop peer relationships.

Similarly, there was a strong correlation between Jamie's ability to make sense of relationships and his behaviour. When his peer relationships were fragile or deteriorated, he had increased aggression towards his peers. This subsequently made peer relationships more difficult for him, entering him into a vicious cycle of feelings, influencing behaviour and affecting his relationships. But while the correlation between relationships and behaviour was clear, the underlying unconscious reasons for this were less so. In light of the evidence, and using the theoretical sources, one plausible interpretation is that he unconsciously used his aggression to keep an emotional distance from his peers. Although this is informed speculation, it matches the findings of previous studies, such as Witvliet *et al.* (2009),

whereby children's positive peer relationships correlated with a reduction in externalising behaviour, such as aggression. For Jamie, this meant he avoided having to face emotional rejection, which had occurred so many times during his life.

An unexpected finding related to this was the experience of shame, felt by parents and carers as their children developed positive relationships with others while away from home. Although this shame was not expressed directly, the transference indicated a link to the feeling of 'failure'. Parents were clearly pleased their child was developing their ability to make relationships, but they questioned why it had taken a move to a residential setting to achieve this. This is a subsidiary effect of the therapeutic placement. One function of the placement is to enable children to become aware of their feelings, which will affect their relationships. As with any therapy, the increased awareness of feelings cannot be isolated to purely positive ones, and the awareness of shame and guilt is evidence of the therapeutic process working. This idea of guilt correlates with the dynamic of shame discussed by Price *et al.* (2017). Whereas guilt can be seen to presuppose responsibility, often referring to feelings of regret about personal behaviour, shame does not. Instead, shame relates to feelings of regret about some aspect of themselves – the 'self-behaviour distinction' (Tignor and Colvin, 2017). The shame experienced by birth families appeared more fundamental and harder to alleviate, linking to the family's own life experiences. For example, the birth parents of Leo and Kerry identified feelings of regret in relation to their ability to keep their child safe. Thus the issue of shame may be considered transgenerational, with children's early-life experiences often matching those of their parents (Furnivall, 2011).

6.2.5 Gender

One surprise in the fieldwork findings is the apparent lack of impact of gender on children's relationships, though this is based on a group of only four children. All four were able to have relationships with male and female children and staff. Although Leo and Kerry had

experienced absence and abuse from a male father figure, both were able to relate to males across both care and education settings within the MBS. This is significant given that almost half of the staff are male. Similarly, both Jamie and Lola, who had experienced a breakdown in their maternal relationships, were able to make relationships with men and women.

Several differences were apparent; for example, Kerry sought physical activities more from males and Jamie appeared more open to discussing his emotions with women. However, the lack of significant gender differences might reflect the manner in which the MBS regards male and female staff – for example, there is no distinction in training, despite the recognition that staff gender may be significant for some children.

From a staff and family perspective, there was a more obvious gender divide, with staff, children and families describing men as being able to stop physically violent behaviours. It was unclear whether this was factually correct, and some children – for example, Jamie and Leo – found it more socially acceptable to be physically held by men than women, preferring to differentiate physical from emotional needs. This links to a much broader societal narrative about the roles of men and women and is not unique to this study or setting, but it is a helpful consideration. For example, research suggests that many children view women as more emotional and men as more authoritative and physical (Brody and Hall, 2008). The evidence from this study does not necessarily support this view.

The move from children understanding their feelings to developing and maintaining relationships is central to this study's exploration of the effect the therapeutic environment can have. This development is seen to directly relate to changes in the children's behaviour, and how children and adults perceive these.

6.3 Perspectives on behaviour

There is a strong link between the experiences of children and families, their feelings related

to these and their subsequent behaviour. Figure 5 highlights how children's experiences shape their feelings, impacting their behaviour and, subsequently, their ability to develop and maintain relationships.

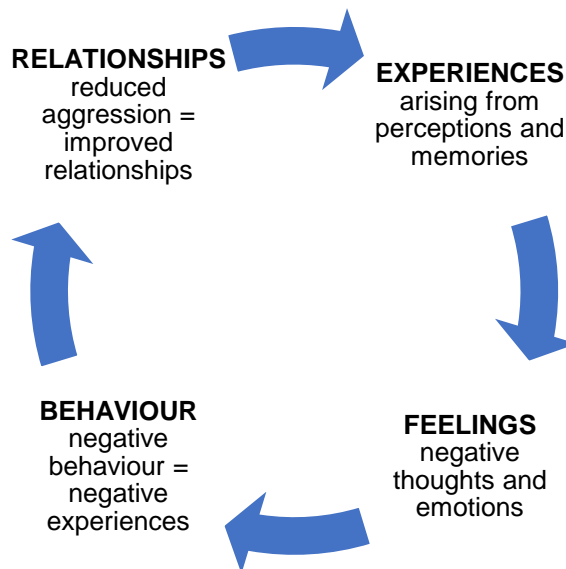


Figure Fig 5: How experiences shape relationships

There was a consensus that, before MBS attendance, children had a limited understanding of their feelings, often unconsciously separating them from their experiences and memories of trauma. This can be a life-saving defence mechanism in the short term, but can also prevent long-term integration (Bloom, 1999), leading to a limited capacity for concern. This separation of feelings from experiences impacts their ability to develop relationships and subsequently impacts their behaviour. In this study, staff, parents and carers all noted improvement in the children's ability to recognise their feelings and develop relationships, but what about behaviour?

There were considerable improvements in behaviour throughout the children's placements, although the extent of this improvement varied between the four children, and staff- and

family-reported outcomes did not all converge. Dooner and James (2019) noted that participant outcomes could be expected to diverge and that not all participants would have identical perspectives. Research on the MBS (Gutman et al., 2018; Harriss, Moli, et al., 2008; Price et al., 2017) has drawn attention to a wide range of educational, social, behavioural and emotional outcomes. This is consistent with my own findings, but the evidence also points towards some additional points that are worth exploring.

The multiple examples of improved behaviour predominantly focussed on reduced levels of aggression, violence and antisocial behaviour within the home, complementing previous research (Harriss, Barlow, et al., 2008). There was evidence of a reduced need for a defensive, fight-or-flight response to group situations (Bion, 1961). However, more nuanced examples included Lola being able to go out with her carers in public – for example, shopping – and to play with other young children – something they had not previously experienced. This brings into sharp focus the value and importance placed on relationships by children and families (Dods, 2013). Kerry's parents said that she still got cross, but rather than hitting out, she would take herself to her room before explaining why she was cross. This indicates a move towards developing an internal model of self (Ward and McMahon, 1998). Jamie's and Leo's parents also described reduced tension and anxiety in the house, which appeared to lead to less disruptive and aggressive behaviours. However, this was not exclusive to the children; both boys' parents were able to acknowledge their emotional responses to having the boys at home. Both described being 'at breaking point' at the point of placement and being emotionally relieved to have a placement. This is a salient reflection of the parents' transference and counter-transference with their children. The parents are more able to provide a contained 'inner mental space in which the child's feelings can be borne, thought about and in due course passed back to the child in a more manageable form' (Ward and McMahon, 1998, pp.33–35).

In addition to improvements in behaviour, Leo's mother described an important physical change, which matched evidence relating to all four children. Children who have experienced early-life trauma often display stress responses through increased heart rate and rapid breathing. Van der Kolk (2014) highlighted that this can occur throughout the day, not just at the point of stress, something which Leo's mother and staff linked directly to the children. Descriptions of the children indicate a more stable heart rate and levels of breathing, supported by internal MBS measurements (Mulberry Bush, 2017b).

One of the most notable points about this sense of containment was how soon they experienced these improvements in behaviour. The parents of both girls saw improvements from the first time Kerry and Lola came home, which would have been no more than three weeks after starting their placement. This exemplifies Winnicott's idea of the holding environment, whereby the development of relationships is triggered after the child experiences an environment/milieu which offers the context for healthy child development. The parents of Leo and Jamie noticed similar improvements over a more extended period: months rather than weeks.

In understanding this extended period, several other considerations arise. Firstly, there is the idea, raised by some members of the care staff, of children having a 'honeymoon period', whereby things go well for a short period at the start – for example, reduced aggressive behaviour. However, this is a rather catch-all phrase that feels unlikely to explain the children's behaviour, as the behavioural improvements appeared sustainable, certainly for Leo, Kerry and Lola. More likely is the explanation given for improvements in relationships, the idea of children unconsciously splitting between home and the MBS. A further factor worth considering is the children's fear, conscious or unconscious, of losing their home placement. All would have been aware of other children being removed from their families and placed into foster care; all were aware that their placement at the MBS was a 'final chance'. When considering emotional trauma and attachment, we must also be aware that

the children are simply that: primary-aged children. Both boys had internalised that the MBS was their 'final chance', whether they had been directly told this was unclear.

Lola's carers observed that, while her aggressive behaviour significantly reduced, her awareness of swear words increased. She experienced high levels of swearing within the MBS, but this was also an example of progress. Her ability to verbalise her frustration was a noteworthy improvement over expressing this through physical assaults on others. This shows an improved understanding of her actions, stemming from an increased understanding of her emotional state, or the development of a 'capacity for concern' (Winnicott, 1963b). While there is a conscious component to improvement, it is primarily a series of unconscious processes, indicating a developing sense of emotional containment arising from the staff and the therapeutic environment.

This idea of containment was supported by the children themselves. Initially, both boys seemed unsure, or ambivalent, about changes to their behaviour. In contrast, the girls seemed clearer and prouder, making comments like 'I don't ever hit anyone at home now' (Kerry). This might be understood as the girls developing new self-narratives, a new internal working model of self and others (Ward and McMahon, 1998). Between the first and final interviews, all four children referred to their changing behaviour in terms of 'not needing to be held' (at times, children are physically restrained for their own and others' safety). Internal data supported this for all the children, but the data for the girls was particularly apparent. Kerry, who had regular aggressive and violent outbursts, showed no signs of aggression after joining the school. This shows that her feelings were more emotionally contained by the structured and therapeutic environment, which could tolerate her emotions and help her process them. This also highlights the ideas of Hannon, Wood and Bazalgette (2010), who argued that, for healthy psychological development, the unintegrated child needs to experience the 'holding environment', which the MBS strives to provide.

While Kerry and her family were incredibly pleased with the cessation of her aggression, the staff questioned whether this was a positive thing, or whether she was internalising, not allowing herself to exhibit her feelings through her behaviour, and thus avoiding the therapeutic work of understanding her feelings and relationships. Kerry was a child who, at the point of referral, could have been referred to as a 'frozen child' (Dockar-Drysdale, 1968). She did not make relationships and her behaviour appeared more primitive; she could be charming yet fly into rages, thoughtful of others yet project her anxiety in the group, impacting the group's functioning. She had no concept of past or future and lived in the present. Her early-life experiences meant she had never experienced others as trustworthy or safe. Yet within the MBS, her anxiety levels reduced, as she saw adults were able to keep her safe and experienced the holding environment of the therapeutic setting. At the point of the research, she was starting to recognise not only her behaviours but the impact of these on others, as if her 'frozen' state was starting to thaw. The level of anxiety staff experienced when working with her significantly reduced, linked to an increased ability to contain projected anxiety – something she had not experienced before the MBS. Notably, Kerry's ability to experience remorse grew, indicating a reduced sense of emotional discomfort. In short, as Kerry recognised her impact on others, she developed an increased awareness of herself.

The link between feelings, behaviour and relationships again needs consideration. The dilution of intense relationships (Diamond, 2004) within a group setting allows emotions and behaviours to be shared across a wider pool of 'containers' than in the home environment. Both Leo's and Jamie's mothers acknowledged that when their sons were excluded from school, they were often left to manage their son's behaviour for a prolonged period. Notably, some of the children recognised the benefit of having different staff teams, allowing for a 'fresh start'.

The findings highlighted a decline in the children's behaviour towards the end of the placements. This was recognised by staff across all MBS departments, including senior managers, and by Jamie's family, but was not supported by any literature other than MBS internal reports. This behaviour could represent the increased level of anxiety held by the child, and possibly their family, as the withdrawal of the containing function of the MBS drew nearer. The containment, highlighted by Haigh (2013) as a core element of a therapeutic environment, is experienced through relationships; thus, as the child, and possibly staff, begin the process of disengaging, it appears natural that the level of containment should reduce. A further consideration is whether this links to children's attachment patterns, similar to the baby's response when the caregiver withdraws. This may be worth considering for future research across the sector.

6.4 My child can't be in a group

As with the development of relationships, the group-work model, a crucial therapeutic concept, sits at the core of the school's work (Diamond, 2004; Dockar-Drysdale, 1993). One of the more surprising findings was that staff appeared unclear about the value of groups. On reflection, this may be due to the staff's lack of clarity and training in running groups (Staines, 2017). However, this matches the literature review: the use of groups does not feature compellingly in previous MBS research (Gutman et al., 2018; Harriss, Moli, et al., 2008; Onions, 2017a; Price et al., 2017) suggesting a potential separation between the understanding and the use of group-work, with a lack of theoretical description of its role and value.

Despite the managers and trustees being clear about the role and value of group work (discussed in chapter two), the lack of understanding from other participants was surprising. Senior staff identified an active link between children's individual treatment needs and involvement in group settings, offering a clear strategic view of group work. However, most

front-line staff appeared uncertain about the children's involvement during formal group settings and how this linked to overall treatment plans (internal documents detailing the therapeutic needs and intervention for each child). Kerry's treatment team manager described her as 'being in a group, I think', bringing into focus the uncertainty around formal group work and suggesting an ambivalence towards the group, which may be regarded as a projection from Kerry rather than the manager's own feelings. This uncertainty was supported by families and carers, who also appeared unaware that their child was part of any group spaces, or what the therapeutic function of these might be. This finding was also evident for the children. Although group work is central to the school's theoretical model, it is not clearly articulated or operationalised by staff. Yet the evidence supports the views of authors such as Button (1997), who describe the caring role provided by the group and the ability to hold 'big feelings' such as guilt and anxiety – both of which clearly exist.

Although there is a clear expectation from the MBS that children will be part of group settings, this is not well documented. All of the parents and carers expressed uncertainty about whether their child could engage in a group environment. Previous placements had all supported the view that the children could not work alongside others, either socially or educationally. This view appeared to match that of the children. My reflections on the transference with the children during their first interviews suggested feelings of anxiety and fear about what might happen in the group. However, over subsequent interviews this reduced, and in the final interviews was barely apparent, suggesting the children's anxiety about being in a group decreased as their ability to be part of a group increased.

6.4.1 Understanding group work

As discussed in chapter two, the use of formal and informal group work is central to the therapeutic task (Clough *et al.*, 2006; Sharpe, 2006; Ward *et al.*, 2003). The use of groups within the MBS allows children with similar life experiences to offer support to one another

(Lindsay and Orton, 2011) which otherwise could be missing. However, this caused some anxiety among parents and less senior staff about the impact of vicarious trauma (Pearlman and Saakvitne, 1995) upon the children.

Despite MBS literature and the views of senior staff on the importance of the group-work model, this model was unclear to the children, some staff, parents and carers. The literature and interviews with senior staff identified formal group-work structures as those with a planned therapeutic value, and included class circle times, end-of-day meetings in the houses, weekly community meetings, small group activity sessions and therapy groups. These differed from informal group-work opportunities that were generally more social and less structured, including mealtimes, playtimes and class lessons. However, although formal group-work spaces were more structured, the value attached to them by staff appeared comparable with the less structured, informal group-work spaces. This again suggests limited recognition of the model and the value of group work. This aspect of group work is given as an example of the analysis and interpretation of findings in appendix 11.

Parents and carers expressed a view that their child was unable to be in groups, and were uncertain about what these groups were. However, when interview questions were reworded, they all gave examples of their child being alongside other children – i.e. in a group setting – at the MBS. Given the significance of the group-work model to the MBS, this lack of understanding appears to undermine a core component of the therapeutic work. However, rather than directly relating to how the MBS affects the children, this appears more linked to other themes about how the effects are understood. For example, two families remember being told about groups, though neither set of birth parents recalled this. They recognised the effect the MBS had, but struggled to understand what had occurred. This is understood to reflect the ‘breaking point’ the birth parents felt at the point of referral, making it impossible for them to hear what was said about the school, rather than reflecting on the group-work model itself.

In comparison, the children's concept of group work distinguished between formal and informal group settings, recognising the formal groups, but failing to see the informal groups as part of a group-work model. The children may simply not have understood the terminology, perhaps due to staff not being clear. This lack of clarity was operationalised through the avoidance of group spaces, suggesting that the 'not knowing' was, at least in part, a way of avoiding uncomfortable group experiences. Reflecting on the transference I experienced during the interviews, I was aware of feeling avoidance from the children and some staff about being alongside others. When alongside the children during formal group settings, I experienced as projected feelings from the children, and observed in the children, their desire for 'flight' (Bion, 1961). When reviewing my reflective notes, there were at least four references to such avoidance, relating to each of the children. These were reinforced by male and female care staff, who described their counter-transference as matching this sense of avoidance. Children resorted to a fight-or-flight defence in order to avoid group spaces, often through aggression (Bion, 1961). This corresponds to Perry's discussion of children's early-life trauma impacting their ability to form attachments, and meaningful individual and group relationships, meaning they often mistrust others (2006). Before children can explore the group environment and relationships, they must develop one-to-one relationships, in the same way that a baby develops individual relationships before becoming a toddler who can explore, play and socialise.

Kerry and Leo spoke about each other in a manner suggesting some basic level of friendship. There was perhaps some unconscious identification with another child from the same family background, as both still resided with their birth mothers – though with a sample of only two children, this can only be suggested. Further research might investigate whether children who still reside with their birth families retain an unconscious ability to form stronger peer relationships, potentially as a result of having had far fewer placements.

However, all parents spoke, with prompting, about how their child was more able to be in both family and social groups since being placed at the MBS, even though all the families found it hard to identify what had led to this change. The findings indicate parallels between the understanding of group work and the ability to partake in it. Without understanding, there is limited ability, but as the ability develops, so does the understanding.

6.4.2 The intensity of group work

This section discusses the emotional intensity of group settings. To recognise and process the experiences of traumatised children in a group space (holding environment) is an intense part of the therapeutic task. Staff spoke of experiencing intense emotional transference from the children and the resulting need to recognise and work with their own counter-transference. This intensity of emotions can be related to the previously discussed anxiety around vicarious trauma (Pearlman and Saakvitne, 1995) and appears indicative of an emotional avoidance of this part of the work from some staff, albeit unconscious. There were several examples of the children avoiding groups which I felt to be more conscious, but again to avoid an anxiety-provoking experience. However, the use of groups did not appear to be related to the skills and experience of the staff leading the groups. There is evidence of differing expectations for children in different parts of the MBS and between different staff members. For example, education staff allowed Leo to remove himself from the class group, allowing his fight-or-flight defence, while care staff felt it was a requirement to be in group spaces. There was considerable anxiety among some staff members about using the group to discuss the children's feelings. This was understood to represent staff anxiety about how important, but difficult, emotional management can be; some staff were able to recognise their anxiety about whether they would be able to contain the feelings and anxieties, should they be allowed to come to the surface (Menzies Lyth, 1988). At its most primitive level, this represents the staff's fear for their own emotional safety and of becoming overwhelmed with the intense and abusive feelings of the children. The MBS's model of reflective practice here

poses an interesting paradox. Staff make use of reflective practice as a means of 'trying to make sense of the uncertainty in our workplaces' (Ghaye, 2000, p.7), yet making sense of this creates anxiety. This paradox sits at the heart of the MBS's work: the group supports the containment of such anxiety and allows emotional processing of the overwhelming emotions.

Children and some staff find individual provision more emotionally containing and safer than group experiences. This connects to child development ideas about children needing safe, one-to-one relationships before moving on to socialise in groups. Staff interviews highlighted that, although emotional intensity can be greater on a one-to-one basis, children and staff often seek out individual opportunities to avoid group spaces. Several participants highlighted children, such as Leo, being resistant to the therapeutic group work. However, an alternative understanding is that he was engaged in this process – evidenced by the progress he made during his placement – but was resistant to undertaking this emotionally challenging work in a group setting. This is supported by his growing ability to be within a family group setting, which is smaller than the groups he experienced at the school.

6.4.3 Are there wider issues?

In addition to Bion's three basic assumptions³⁵ discussed in chapter two, an alternative difficulty in group participation is Turquet's (1975) fourth basic assumption of 'oneness', also discussed in chapter two. Whereas Bion's ideas focussed purely on the functioning within a group setting, Turquet (1975) considered the wider impacts upon group functioning, yet both refer to defences against the emotional intensity of group spaces. To overcome such defences and protect against emotional intensity, the MBS has moved from historically intense relationships, with a small number of staff for a larger group of children, to a more shared model, with a larger staff team and smaller groups of children (Diamond, 2004).

³⁵ Bion identified three assumptions which groups might unconsciously adopt as a way to interfere with the assumed group task: dependency, fight-flight and pairing.

The idea of 'oneness' fits well when considering that children and families have often experienced their society as chaotic or abusive, leading to the breakdown of relationships. Whether in wider society or the micro-society of the MBS, several staff participants – primarily those in the care teams – referred to the 'chaotic nature' of the work. This represents the less structured approach of the care teams compared to the education teams.

Perhaps as a response to this 'chaotic nature', in recent times the school appears to have reduced the focus on the therapeutic work undertaken within large groups. This is explained in several ways. The change in population within the school (Rollinson, 2018) has challenged how children can access the group model. This is coupled with a broader shift in residential settings, which now require far higher staffing ratios and smaller units (Ward, 2006), making group-work models appear less relevant. Thus, the statutory requirements can be regarded as working against group-work models – the increased number of staff leads to more unconscious opportunities to avoid group situations.

Despite the unconscious move away from a group-based model, and the mixed understanding of the model, it is clear that groups benefit children. The use of groups is related to the ability to make one-to-one relationships, explored earlier in this chapter, in turn helping children to tolerate group settings and making use of the therapeutic value of being with others. This tolerance of groups significantly improved their ability to function in group settings and was experienced most significantly in the smaller family environment. However, the level of anxiety across family and school group settings remained high, representing the emotional intensity of working with trauma (de Thierry, 2015).

6.5 Caregiving and the emotional impact of working with trauma

The literature attests to the relationship between early-life trauma and difficulties with attachment (van der Kolk, 2014; Perry, 2007). However, despite a cogent body of literature detailing the social, emotional and psychological impact of early-life traumas (Bombèr, 2007; van der Kolk, 2005; Perry, 2007; de Thierry, 2015), the full impact of children's early-life experiences was not consistently understood by families, staff, professionals or the children themselves. While only two of the participating children discussed their traumatic backgrounds, they did so as a set of factual events, disconnected from their behaviours, feelings and placement at the school.

The findings highlight a lack of discussion with the children relating to the reasons for their placement. When children believed their placement was due to their behaviour, they were unclear of the expectations placed upon them. Both Kerry and Leo stated that their placement at the MBS was to enable them to 'behave properly'. This brought to light parents', carers and several education staff members' perceptions of the children's behaviour, which overtook the emotional trauma. This meant the trauma and abuse became hard to discuss – a point stated by staff working directly with Kerry, Leo and Lola. The children focussed on their negative behaviours, as professionals and families had done prior to the MBS, rather than the underlying reasons. Although not discussing childhood trauma, the ideas of Menzies Lyth (1988) help clarify this focus as a defence against the emotional trauma and also a defence from staff. Taking focus away from the horrific, early-life complex trauma 'protects children' from it, and from the potential negative perceptions which may arise if it is brought to consciousness.

However, as the children's placements at the MBS progressed, this protective focus shifted from the children's behaviour to their emotional trauma. In the initial interviews, only Jamie made any reference to his early-life experiences, stating that if his 'mother had not abandoned him, he would be OK'. This not only represents an unconscious defence against

the emotional trauma, but raises the question of why Jamie, the only adopted child, had this awareness, which conflicts with Winter and Cohen's (2005) view that adopted children often experience less awareness of their birth families. It appeared that Jamie had a greater capacity than the other children to make sense of his early-life experiences. Staff discussions reflect the difference in his attachment patterns compared to the other children. While all the children experienced a breakdown in early-life attachments, Jamie was the only one who, through being adopted, experienced a 'second chance' at creating a new attachment. However, this also meant his attachment model was in conflict with itself, in a clash between his birth and adoptive families which could be explored through the introduction of a third parental figure, namely the MBS, again giving rise to the difficulty of shared parenting (Onions, 2017a). This defence can be related to the families – particularly the birth families, such as Leo's and Kerry's – who continued to live with the impact of the trauma. Again, it is clear that the trauma had become 'lost' and the behaviour, particularly aggression, was prioritised.

This defence links to the idea of vicarious trauma, discussed by Pearlman and Saakvitne (1995), highlighting the emotional impact staff experienced working and talking about trauma with the children. This supports my findings, which identify discomfort and uncertainty among MBS staff about what can be discussed with the children, and the impact on themselves of talking about trauma. While the management perspective was that the staff team were consistent in their ability to discuss children's life events, this was at odds with the evidence. Although both teams experienced the intense projections of the children's trauma, the evidence suggests a difference in how these were recognised and experienced by group living and education staff. Care teams, primarily the more experienced staff and keyworkers, referred to the children's early experiences and to the impact on themselves of working with the trauma. They spoke, at times, about feeling overwhelmed by the intensity of the children's projections, sometimes with sadness and despair, and sometimes with anger and

rage. This differed from the education staff, who spoke more about the impact of behaviour on children's learning rather than directly upon themselves. This suggests a further split between school departments, though it is unclear whether this split arises from the children or is more organisational. Although this split is an example of Klein's defence against anxiety – the splitting of 'good' and 'bad' qualities onto others (2011) – it may reflect different professional tasks, and it should be considered whether the more structured educational task provides a level of organisational defence for the staff.

My reflective notes further highlight the vicarious/secondary trauma which staff are subject to (Pearlman and Saakvitne, 1995). The projection of uncertainty and anxiety that I experienced from staff – almost an unspoken sense of 'do we know what we are doing with this child?' – was apparent through many interviews. This reflects the extreme levels of trauma and anxiety carried by each child. At an unconscious level, staff may question whether this can be 'repaired' or whether the work is too hard or even impossible, and thus whether they are 'good enough' to care for the children. This may, unconsciously, give rise to the vicarious/secondary trauma which is widespread across the care sector (Pearlman and Saakvitne, 1995).

At a more conscious level, staff interviews showed greater use of psychodynamic and reflective practice language (e.g. 'projection', 'transference', 'defences') among the leadership, T&NT and care team than in the education team. While this might reflect a different level of understanding, all staff undertake the same training programme, so it may be more related to the task and the structural organisation of the school. For example, many of the care staff had worked, or were expected to work, with children for up to three years, with a focus on relationships, while education staff focussed more on learning and spoke about unclear timescales, as children moved classes but not residential houses.

6.5.1 *The anxiety of living with not knowing*

This section discusses the management of anxiety and links to the therapeutic model, as well as our defences for avoiding this. The understanding and management of anxiety are a core part of the therapeutic work – a view shared by management participants. Mosse (1994) recognised that anxiety can be crippling for an organisation, negatively impacting communication, trust and the ability to work together. Within the MBS, anxiety can be a form of defence against emotional pain, making it complex to make sense of.

Much of the anxiety stems from significant gaps in the knowledge of the children's backgrounds, referred to by one manager as 'living with the not knowing'. At times this 'not knowing' referred to specific questions about a child's past – for example, the exact nature of Leo's early-life trauma. But often this was non-specific, leading to overwhelming anxiety, which at times was overcome by interpretations and judgements. This idea of the unknown creating anxiety is significant and not unique to the MBS, as recognised by Menzies Lyth (1988). Although interviews were not undertaken with non-MBS professionals, the evidence from families, staff and documentation indicates high levels of anxiety for children and families pre-MBS placements. While anxiety is recognised as a natural human response, at an individual and organisational level (Menzies Lyth, 1988) it relates to children's early-life trauma. In terms of psychodynamic theory, anxiety links to Freud's early work, being created from a conflict between the unconscious and conscious parts of the mind and dealt with by the ego's defence mechanisms (Mcleod, 2017). Bowlby (1958) further discussed the idea that early-life trauma, or a breakdown in attachment, might lead to heightened anxiety. Where anxiety is referred to within this chapter, it is understood to be overwhelming and stemming from early-life trauma (Lubit *et al.*, 2003), rather than the everyday anxiety most people experience (NHS, 2018). Interestingly, Bowlby also discussed the idea of 'not knowing' in his paper 'On knowing what you are not supposed to know and feeling what you are not supposed to feel' (Bowlby, 1988). This relates to children who experienced and observed traumatic events, but whose parents/carers wished to exclude these experiences

from thought, as denial or avoidance. Although interviews were only undertaken with two of the birth parents, this matched their wish not to talk about or acknowledge the traumatic experiences. Despite not interviewing Lola's and Jamie's birth parents, this idea appeared just as relevant and paradoxically indicative of the need for a therapeutic placement to enable the children to address their early-life experiences.

The idea of heightened anxiety relates to the significant amount of unknown information, and to the children's overwhelming sense of 'not knowing', which they project as anxiety onto those around them. For example, where families and children do not know aspects of past traumas, through repression or denial, this leads to increased anxiety. Managers and staff acknowledged that, across the school, there is a high level of anxiety and 'not knowing', sometimes about factual information, but more frequently about not knowing, for example, 'who will respond to me?' or 'will carers come back again tomorrow?' It is not as simple as 'finding out' what isn't known, but rather of living with intense uncertainty.

This suggests a link between 'not knowing' and the 'need for a therapeutic placement' – a point implicit in the interviews with managers. These findings suggest that a core part of the therapeutic task is to manage such anxieties, from the children, families and staff, which arise from 'not knowing'. This links to children's ability to develop trusting relationships and their anxiety about whether those relationships are safe and can emotionally, and sometimes physically, contain and keep them safe.

Paradoxically, the nature of the 'unknown' can be considered 'known'. The lack of relationships stems from children's lack of previous secure attachments, giving rise to heightened anxieties and subsequent behavioural issues which represent a defence against the anxiety. For example, staff described how Jamie would become anxious when faced with not knowing something, such as changes in staffing structures, and he exhibited this through

extreme levels of aggressive behaviour and projections onto staff. The evidence and literature suggest this stems from his early-life experiences, whereby his mother could not meet his emotional needs, leading to a lack of containment. His behaviour communicates his anxiety – ‘I don’t know if you can keep me safe’ – whether regarding an individual relationship or the broader therapeutic setting. In this example, the ‘not knowing’ is ‘known’, but the anxiety is prevalent, rather than the ‘not knowing’.

Jamie’s anxiety relates to Bion’s idea of ‘container/contained’ (1962): taking the baby’s feelings, processing them and handing them back in a contained and manageable way. Winnicott believed this only occurs within a healthy environment, the ‘facilitating environment’, and in the presence of the ‘good enough mother’ (Winnicott, 1965). These ideas were referred to by several staff, managers and the chair of trustees, all of whom mentioned staff having to tolerate the children’s unmanageable feelings, particularly anxiety, to process them and give them back in a more manageable manner. However, several participants recognised that this is not always emotionally possible, that this anxiety can be experienced as a ‘lack of containment’, leading to further anxiety and a vicious emotional circle. For staff to model the containment of such emotions, they need ways to process them without becoming overwhelmed, otherwise the children will experience these feelings as impossible to bear (Canham, 1998). This ‘lack of containment’, and the spilling out of emotional pain (Winnicott, 1963a), results from avoidance of the children’s emotional pain, which is precisely what is trying to be contained. Through reflection, staff recognised the transference and projected feelings they experienced from Jamie, particularly anxiety. Senior staff recognised that when these anxieties could not be emotionally contained, they resulted in anxiety-provoking behaviours and a cycle of anxiety across the organisation, of which many examples were given.

The therapeutic model addresses these anxieties through relationships and reflection. However, although Diamond (2004) argued for a measured emotional distance within these

relationships, staff inconsistently understood or practised this. Staff in the care team, particularly keyworkers, indicated closer relationships – similar to those described by Dockar-Drysdale (1990) – than education staff and, naturally, those who did not work directly alongside the children. This indicates that written models of working, such as Diamond's 'emotional distance regulation', may be articulated but not operationalised by staff working alongside the children. However, changes to models of working with relationships are needed at a cultural level, meaning they can take time to be introduced and accepted.

One way of accounting for this understanding, while linking it to the ambiguity about the therapeutic model, is that there exists an 'organisational defence' against clarifying the exact nature of the work. If it is too clearly defined, staff will be left holding the overwhelming anxieties of the children. Thus, the lack of clarity in the 'therapeutic model' serves as a defensive function, mirroring the anxiety and the 'not knowing' which exists for those trying to understand the children's life events. This clarifies the repeated findings relating to a lack of understanding of the model and the emotional impact of the direct work. Of course, these findings may be explained more basically as 'things are unclear' and 'children are anxious', but this seems rather simplistic, akin to looking only at the behaviour, and not recognising the communication behind it. It is difficult to comprehend that in an organisation with such good outcomes (Gutman *et al.*, 2018; Price *et al.*, 2018) the understanding of the model is simply unclear. Rather, part of the therapeutic task is to help clarify that which is unclear. The evidence clearly indicates a genuine confusion about children's life events. However, it is also plausible – and the evidence can be interpreted to support this – that an emotional defence against wanting or being able to fully acknowledge the full detail of their experiences exists. It may be that the children's early-life experiences are so traumatic that some staff are emotionally unable to get in touch with them and the nature of the therapeutic approach to address them. Staff speak of being able to reflect on the projections they received when working with the children, understanding that they – particularly Leo and Jamie – were often resistant or unable to reflect on the feelings behind their behaviours. This supports the role

of reflective practice throughout the organisation, recognised by all staff as helpful for managing such intensity.

Staff are aware that attachment and relationships are core to the therapeutic model, but clearly the sense of safety and containment discussed by Haigh (2013) is lacking for some staff, particularly those newer to the school. This suggests staff have the knowledge – for example, through training – but for some this does not translate into their emotional experience. Using Haigh’s (2013) concepts, and considering the findings, there appears to be a discrepancy, in practice, between Haigh’s model and the MBS’s model. This relates to the authority invested in service users and the understanding that the expertise is held by service users rather than expert therapists. While Haigh’s model (2013) is widely used in adult therapeutic settings, the school has had to adopt a modified approach to reflect the emotional and chronological ages and stages of the primary-aged children.

The school’s literature states that it is based on attachment theory, complex trauma, group relations, neuroscience and ideas drawn from therapeutic community, planned environment and milieu therapy (Diamond, 2013). However, this was not reflected in the staff interviews, except for those with managers and trustees. Staff working directly with the children were able to discuss their attachment work and work with families (systems theory) and complex trauma, but there was limited reference to therapeutic community principles and no reference to neuroscience. This may reflect the newness of this way of thinking, but it raises questions about whether this is part of the MBS’s core theory base or an afterthought, and whether it is fully understood and utilised. Management interviews highlighted the need for the school to develop and include new understandings while holding on to the founding principles. Here, neuroscience can be considered a ‘new understanding’, but one which directly supports the psychodynamic and therapeutic task (Ouss-Ryngaert and Golse, 2010). Perry (2006a) and van der Kolk (2014) have discussed the physical manifestations of trauma on children’s bodies and how regulation-based activities offer support during times of

heightened distress. Such ideas were discussed by managers and appeared in Jamie's documentation, but other staff made no mention of regulation.

While the treatment plans for the four children refer to their early-life complex trauma, which will have a neurological impact (Perry and Pollard, 1998), only Jamie's referred to neuroscience. This again suggests a gap between what is described and what is practised, representing a reduced level of staff understanding, but also, using the ideas of Menzies Lyth (1988), a more organisational issue. The concept of an emotional staff defence against new ways of thinking appears pertinent. Primitive anxieties caused by working with trauma, whether that is the death and suffering described by Menzies Lyth or the levels of child deprivation within the MBS, can lead to rigid and maladaptive defences embedded in work settings.

6.5.2 *Getting it right*

The concept of 'not knowing' and the defences against anxiety both relate to the theme of 'getting it right'. Senior staff and trustees appeared anxious during their interviews, each commenting, 'I hope I get this right'. This is a salient comment, highlighting the management's responsibility for containing the 'not knowing' and the projections from staff towards management that 'surely those at the top must know'. However, it may also indicate an unconscious awareness that their responses would be recorded and critically reviewed. Reflecting upon this, and with reference to the psychodynamic framework, this refers to an organisational anxiety about what it means to 'not know everything', as if this meant failure.

Consideration has been given to the different forms of anxiety and how these relate to various participants. For example, the anxiety expressed by managers and trustees was consciously perceived and named and appeared related to the research. Reflecting on these interviews and on the idea of 'getting it right', I question whether the anxiety they held was

more related to 'what the research might identify' and what that might mean for the organisation, of which they are leaders. It is also essential to try and separate my anxieties within this example. Returning to my reflective field notes, I recognise my unease in interviewing my line managers and trustees, given my dual role in the MBS. Thus, it is crucial to recognise that while the managers and trustees named their anxieties, my own unconscious projections may have helped create an anxious interview environment. The potential impact of this has been reduced using Schön's (1987) ideas of 'reflect-in-action' and 'reflect-on-action', whereby I have aimed to understand these processes during the data collection, but also, having recognised my own emotional responses, to set these to one side in my mind or through the reflective notes taken after each interview.

These anxieties differed from those identified among staff working directly with the children and families. They seemed unrelated to the potential research findings, but directly related to the management of children's intense emotions and the need to contain these while recognising and containing their own emotional responses. Referring back to Winnicott (1958), we are reminded of the importance of recognising how the emotional problems of child development are integral in a therapeutic approach. It is necessary to recognise that anxieties held by children and staff differ. Children are more likely to experience an overwhelming sense of anxiety, while staff, it would be hoped, have a higher capacity to manage their own anxiety as a result of the therapeutic support and training within the MBS. Here it is worth considering Menzies Lyth's (1988) work on recognising staff anxiety and whose feelings the staff are experiencing – i.e. their own, or projected anxiety from the children. This parallels the projected anxiety I experienced when interviewing managers and trustees.

This feeling of 'getting it right' links to Leo and Kerry, who both appeared resistant to interviews, only completing two of the proposed three. This avoidant defence reflected their anxiety about saying the right thing, and about being in touch with something painful,

suggesting active emotional avoidance of their feelings. This, again, links to the anxiety of 'not knowing' and the fear of whether they would get the interviews 'right'. Notably, it was Leo and Kerry who found it most challenging to put anything on their timeline – whether words or images. The emotional transference I experienced from them involved overwhelming anxiety, confusion and, at times, avoidance. Yet they were also the children who came to my office to 'check things out'. The anxiety about 'getting it right' was also apparent when meeting their families, both of whom spoke confusingly about significant traumatic events and used the phrase 'didn't know' several times. The evidence from families included multiple references to having 'got something wrong' with their child; the parents wondered if they could, or should, have done more or done something different.

This anxiety about 'getting it wrong' explains the apparent need for structure expressed by some of the staff working with the children. The account from a male staff member working with Leo, and the teacher's story of working with Jamie, highlighted that both children required high levels of structure and certainty, linking back to Jamie's dislike of change. It is noteworthy that only the two boys demonstrated this need for structure. Whether this is a gendered difference cannot be established from this small sample, and this could be explored in further research.

When talking about the MBS's model of reflective practice, the focus group participants and senior staff discussed the themes of 'living with the not knowing', 'getting it right' and 'managing anxiety'. Senior and care staff, in particular, identified the emotional impact on themselves and the value of having a culture of reflective practice as a means to understand this. As discussed in chapter two, Schön's concepts of 'reflect-on-action' and 'reflect-in-action' are key to enabling staff to recognise 'whose feelings they are feeling' and thus to understand and manage the emotional impact on themselves. These ideas fit alongside both Winnicott's 'holding environment' (1963b) and Bion's ideas of 'containment' (1963). All three concepts relate to the child giving overwhelming feelings to an adult to process and return,

yet this is dependent on the adult, whether parent or carer, having the emotional capacity and self-reflection to do this. The intensity of the projected feelings from the children made it impossible, at times, for the staff to reflect while working alongside them ('reflect-in-action'; Schön, 1987) with staff experiencing what Bion (1967) referred to as 'attacking the adults thinking'. Yet subsequent opportunities for reflection with peers ('reflect-on-action'; Schön, 1987) enabled them to make sense of the projected feelings. The overwhelming nature of the children's projections and the pressure on staff to provide a container for such distress, similar to the maternal figure (Bion, 1959), was clear. However, it was surprising that the evidence explored the emotional impact on staff but not the physical aspects. Although staff made multiple references to physical assaults, particularly from Leo and Jamie, there was no mention of this being a prohibitive factor in 'reflecting in action'.

6.5.3 Being in therapy vs the therapeutic environment

The impact of trauma can also be seen in the lack of understanding about the difference between being in 'therapy' and being in 'a therapeutic environment/milieu'. Professional documentation for each of the four children referred to prior individual therapy, provided by a qualified therapist, which had ended, and the subsequent need for a therapeutic placement. However, there was contradictory evidence about whether the professionals understood the difference between the two (see chapter two).

This difference was identified by families, particularly Leo's and Lola's, who were unsure why the children did not have individual therapy and felt they did not know what a therapeutic school was. Although Jamie and Kerry acknowledged that they were currently meeting with a particular therapist, none of the children could articulate what made the MBS therapeutic. Leo suggested that his previous placement had 'been more therapeutic 'cos they had a swimming pool I could use when I got angry', suggesting he could recognise that an activity, swimming, was beneficial when he was angry. However, this is a more practical definition of

'therapeutic' than those considered in the literature review (Haigh, 2013; Whittaker *et al.*, 2016), further attesting to the lack of clarity surrounding the term.

Although focus groups recognised the therapeutic environment – for example, one staff member acknowledged the use of the '24-hour curriculum' to provide 'emotional containment for children' – there was confusion among care and education staff about which children were having individual therapy. This appears similar to the confusion around the use of group work, and it was surprising given that the focus groups were made up of staff working directly with the children. This indicates that staff struggle to differentiate between 'therapeutic' and 'being in therapy' and give insufficient attention to the benefits of each. Senior and T&NT staff expressed a much clearer understanding, again suggesting that their greater distance from the children's anxiety provided a clearer view of the work, as they needed to defend less against the children's emotional trauma.

6.5.4 Living without trust

Discussing attachment theory, Bowlby (1988) highlighted the need for a secure base before addressing issues of trust. As highlighted, one of the most consistent findings relates to different variations of 'not knowing', including not knowing the language, the model, the child's background and, most importantly, why the children behave the way they do. Individually, these areas are important and can be addressed separately, but the overall feel and lack of trust do not change until the child understands and can make sense of their trauma, which, as stated by the chair of trustees, will take far longer than their three-year MBS placement. This questions whether part of the MBS's task is to prepare children for post-MBS life – something not highlighted by the findings – again suggesting confusion over the task of the MBS, and in particular the boundaries and limits of the task.

As chapter two discussed, Winnicott's (1965) facilitating environment, whereby trust evolves from the experience of being physically and emotionally held in early life, is closely linked to emotional trauma. The findings offer multiple examples of 'mistrust' within relationships, though not always in those words. Kerry's and Leo's parents discussed feeling 'judged' by professionals, implying they did not feel trusted by them. All four children gave examples of interactions with families, staff and other children which reflected their struggles with trust, particularly those children living with birth families. Leo and Kerry lacked trust in external professionals, but also internal MBS education staff. In comparison, Lola appeared more trusting of her foster carers and education staff, indicating that she might be more trusting of those with whom she may not have long-term relationships. Staff, though noticeably not management, questioned whether they were trusted by the children, the children's families and colleagues. This brought to mind the literature (Hart *et al.*, 2015) which implied that, where children experienced early-life complex trauma and a lack of secure attachment, they lacked trust in the adults caring for them. A senior care worker linked the high-pressure working environment and fear of getting things wrong with a feeling of not being entirely trusted. So, although staff verbalised that families, colleagues and the organisation did trust them, the overwhelming sense of mistrust came from the children's intense projections, signifying the complexity and essential need for trustworthy relationships in residential care (Moore *et al.*, 2018).

6.6 Participant expectations

Part of the school's work is to create what Bowlby (1988) referred to as a secure base, from which trusting relationships can be established. The findings strongly indicate considerable improvements in children developing such relationships, although they highlighted that trust remains an issue, complementing the findings from Harriss, Moli *et al.* (2008). However, despite this, there exists a divergence between participants' expectations of children's

placements. While external professionals and MBS staff set objectives before each placement, there is confusion about and limited reference to these throughout the findings.

Staff have extremely high expectations of the children's behaviour, despite the complex behavioural issues which led to their placements. This reflects their expectations not just of the children, but of themselves and the organisation. Management staff recognised the high expectations on the organisation, while several staff from the education and care teams light-heartedly mentioned the pressure to be rated Outstanding by Ofsted.³⁶ Although this was verbally minimised by the staff, I was aware of tension when it was raised. This was clearly an absolute pressure – 'if we are regarded as Outstanding, then my work has to be outstanding' – and was linked to comments front-line staff made about the difficulties of meeting the needs of the distressed children, and having 'outstanding' expectations of them and themselves.

The transference from staff interviews, particularly care staff, suggested disappointment that the child had not made 'even more' progress – a factor recognised by staff working with Jamie and Leo, who identified that expectations had been too high. This disappointment is a further example of Winnicott's (1971) 'good enough mother' and the often overwhelming feelings of being 'not good enough', which were experienced by the children and projected onto the staff team.

These high expectations and feelings of not being 'good enough' related to all four children, but did not appear to correlate with their placement objectives. Over the course of 12 interviews, only two staff mentioned placement objectives – both from the T&NT. This reflects confusion among MBS staff and external professionals as to the function of the

³⁶ The Office for Standards in Education, Children's Services and Skills is a statutory body with inspection responsibilities for schools and care settings. Outstanding is the highest classification they can award, and the MBS has held this classification for over 20 years.

placement: is it to meet the placement objectives or something less defined? This is a result of the lack of containment and the placements feeling 'urgent' due to prior placement breakdowns, as well as the sense of a 'breaking point' and high anxiety levels, as discussed previously.

Education staff showed greater awareness of education-related targets, but, surprisingly, care and education staff showed limited awareness of targets related to understanding emotions and relationships. The teachers' expectations were more aligned to the educational placement objectives, though teaching assistant expectations diverged from these. For example, many of the teaching assistants spoke about the expectations of behaviour in the classroom, but it was unclear whether these came from the teaching assistants themselves or were projections from other parts of the organisation.

Reflecting on the transference experienced during staff interviews, I noticed the warmth and sense of pride the education staff had concerning the children's academic work. This differed from the care staff, who, while able to recognise progress, appeared to hold much higher expectations related to emotional and behavioural developments and demonstrated less warmth. Staff from the T&NT, meanwhile, held expectations of families and children, but with similar emotional warmth to their education colleagues. These differences may also represent the internal splitting between staff teams as a defence (Menzies Lyth, 1988).

The lack of correlation between expectations and placement objectives also exists for the children. This is understood to be denial, relating to Dockar-Drysdale's 'frozen child' (Dockar-Drysdale, 1968), or a reflection of the violent environments they had experienced. If they had grown up amid violence, why should they be excluded for being violent? The children's expectations of their placements were 'to stop hurting' and to 'learn to read', with no reference to emotional trauma or relationships. These interactions are age appropriate for

the children, but also indicate the unconscious aspects of their trauma – events buried deep and hard to be aware of.

It was striking that the children expected their placement at the MBS to fail and that they would be excluded as they had been 'everywhere else'. This reflects their struggles to make relationships and develop trust in others, but is also a negative transference onto the staff. Staff commented on the emotional impact: if the transference is 'you are an authority figure who will exclude me, as previous attachment figures have done', staff must be aware of their counter-transference. There were times when, at least for Jamie, the staff considered excluding him. Despite this, they appeared proud that children were not excluded,³⁷ suggesting that, overall, they recognised that the therapeutic approach provided the required holding environment to contain the children's intense experiences.

For the children, there was an unspoken feeling of ambivalence about someone else making these decisions and their own lack of agency (Haigh, 2013). This was particularly evident with Jamie, who implied he felt limited control over events in his life, again matching the findings of Harriss, Barlow *et al.* (2008). This was reinforced by birth parents', carers' and staff's views that children felt limited involvement in their placement. The adoptive and fostered children appeared more accepting of being placed at the school than those residing with birth parents – a pattern which was also apparent from the staff and child interviews. This can be understood by the different attachments between the child and birth parents and adoptive or foster carers, but it also highlights a correlation between Winnicott's (1963) capacity for concern and Haigh's (2013) ideas about the need for agency as a core concept of the therapeutic task. When the children are unclear about decisions made regarding them, their ability to develop a sense of agency and decision-making is negatively impacted and subsequently so is their capacity for concern. At this point, they resort to what Bion (1967)

³⁷ Although the school does not follow a 'no exclusion' policy, it is extremely unusual that children are excluded.

referred to as 'attacking the adults thinking', which is a defence against both thinking and feeling. The children had often lived their pre-MBS lives in this state.

The changes in parents' and carers' expectations were also striking. All experienced significantly increased expectations of both the school and their child. When at breaking point, they had experienced relief at their child moving to the MBS; their expectations increased to such a point that, in the case of Jamie and Kerry, the parents felt that staff were not meeting these new expectations. This was understood to reflect the progress the parents observed and the sense that their child was capable of achieving relationships and education, as identified by Harriss, Moli *et al.* (2008), despite being sceptical about this at the point of referral. At that time, parents' expectations often matched those of the children – 'will the placement breakdown?' – yet parents showed a greater increase in expectations than children or staff. This again links to the sense of a 'breaking point' which, once removed, allowed parents greater ability to look at their children's futures, rather than 'getting through each day'. An alternative understanding may be that the idea of the placement breaking down was a projection of negative emotions which reduced as the child's capacity for concern (Winnicott, 1953) and sense of self-containment developed, allowing the parents greater capacity for holding their own expectations. This highlights how the therapeutic approach directly affects the children but indirectly affects the family, and the family's ability to recognise changes in their child's behaviour directly impacts their expectations.

Although, on the surface, this divergence from placement objectives suggests a confusing way of working, it is also an example of the therapeutic model of working. Dockar-Drysdale (1993) referred to the school as being closer to a 'living organism than an institutional organisation', recognising that it does not follow rigid structures, allowing for flexibility to meet the complex needs of the children. However, this increased flexibility can be linked to the earlier discussion of inconsistent emotional distance regulation (Diamond, 2004), resulting in confusion among staff about whether such flexibility is the same as inconsistency

– which it is not!

6.7 Summary

This chapter has examined and discussed the findings presented in chapter five, using psychodynamic and reflective frameworks to develop an understanding of the MBS as a case study. The findings have identified that children make significant progress while placed at the MBS and that this is recognised by all participants. However, how this progress has been achieved is less clear to participants, with core aspects of the therapeutic task not being clearly understood. Significantly, children, families and some staff have inconsistent understandings of the term ‘therapeutic’ and find the group-work model difficult to articulate. This represents a defence from individuals and the organisation towards articulating the therapeutic model.

The findings reinforce the idea that children’s severe early-life complex trauma affects their ability to understand their feelings and subsequently to develop relationships. This, in turn, affects their ability to use the MBS’s group-work spaces and make sense of their behaviour. However, the findings show that, throughout their placements, children develop an increased sense of self and awareness of their own feelings, helping them to develop and maintain relationships and supporting a significant improvement in their behaviours.

Although the group-work model is poorly understood, it remains a core component of the MBS’s work. The evidence indicates that it is implicitly used in the work and that children make increasing use of it to understand their feelings, leading to improved behaviour and relationships. However, the use of group work has, unintentionally, moved from the model adopted by the school earlier in its history towards a more clearly defined but less operationalised model. This not only represents a lack of understanding of the model, but

more importantly reflects the emotional impact of living and working in group settings. The emotional impact of the work on children, staff and families has been shown to be significant, leading to a variety of unconscious defence mechanisms against the emotional intensity. This has been shown to link directly with high levels of anxiety, a sense of mistrust and the feeling of not being 'good enough'. These feelings are plausibly directly related to the children's early-life complex trauma and affect all the participants.

The findings have identified that expectations for the children are high, but so are the expectations placed on staff by families, professional networks and the staff themselves. A common theme is the defensive responses to the emotional intensity of the work, for all participants. These findings are brought together in relation to the research questions in the following, concluding chapter.

Chapter Seven: Conclusion

7.1 Introduction

The purpose of the study was to explore whether the MBS's model of therapeutic childcare affected the lives of the children in the school's care. This concluding chapter reflects on the original contribution to the field of therapeutic childcare, recognising that no therapeutic theory of residential childcare exists, making it difficult to place the study in a wider theoretical framework. To overcome this, the theoretical framework of the MBS has been described in detail and used to underpin the collection and analysis of data throughout this study. The chapter reviews what was undertaken throughout the thesis to achieve the aims, considering the research questions identified in chapter one and what the study can offer both the MBS and the therapeutic childcare sector. Following this, the chapter discusses the limitations of the study.

7.2 What has been undertaken?

To commence my study, chapter two presented a literature review, divided into several sections. The first provided a comprehensive review of publicly available literature relating to the school's 70-year history. Although these offered insights into the school's work, they were primarily written by staff members, resulting in potential bias. The review also explored the theoretical frameworks which underpin the work of the school, providing a framework for this study. Particular attention was paid to the theoretical concepts of Bion, Winnicott and Klein, whose works have been historically linked to the MBS's work and continue to inform its practice.

The second part of the review explored emotional trauma. This was discussed from the stance of attachment theory, the ideas behind trauma-informed practice, the significance of

relationships and the impact of violence. These were linked to the idea of Adverse Childhood Experiences (ACEs).

The final aspect of the review provided a broader evaluation of therapeutic childcare. This identified only a handful of studies which reviewed the effectiveness of therapeutic interventions with primary-aged children who had experienced early-life trauma. The review highlighted the complexities of a collective agreement regarding the terminology, highlighting that across the UK and the USA different models of therapeutic childcare are adopted, making a definition difficult. However, reviewing different models provided helpful insights into other settings and a background for my study. The review was completed with a discussion of the literature relating to the MBS's core principles of reflective practice and collaborative working, and the use of group work as a model of practice.

To answer my initial research questions, I undertook a holistic case study of the Mulberry Bush School – a profile was provided in chapter four, which included an outline of how the school's group-work model is implemented. Chapter three's review of the methodology highlights the value of case studies for illuminating a phenomenon (Merriam, 2007). Within this case were four primary-aged children who resided at the school (embedded cases); their profiles are provided in chapter four. The use of case studies enabled me to draw upon a range of data sources in real-life situations. This was primarily achieved through recorded interviews with the four children, their families, the staff working with them and senior managers and trustees from the MBS. The interviews were supported by my observations, reflections and documentation relating to the children and the overall case. This enabled me to build a picture of how the MBS's therapeutic approach affects the children.

Chapter five provided a review of the available data from across the four embedded child cases to build one overall case study, identifying themes and patterns from across the findings. This allowed the data to be refined to identify the most pertinent aspects.

Chapter six analysed the themes and findings. Bringing these together and drawing on insights and theories presented in the literature review developed an understanding of the MBS's impact on the children, identifying a range of unconscious defences, some of which may have existed on an organisational level. This finding had not been anticipated when formulating the research questions. However, it arose in multiple forms across the analysis and thus felt significant.

In seeking to understand the findings and what they represent, I also sought to understand some of the contradictions and surprises which arose from the findings. An analysis and subsequent interpretation of these themes provided plausible conclusions which linked to the research questions. The responses to these are set out in the following section.

7.3 Research questions

Core question: How does the therapeutic approach of the Mulberry Bush School affect the capacity of emotionally traumatised pupils to understand and regulate their feelings and behaviour, and to develop relationships?

Subsidiary questions:

- I. What are the benefits associated with a therapeutic approach, and what are the limitations of any such approach?
- II. How does a 'group-work' model impact on the children's ability to develop relationships?
- III. How are changes to children's behaviour recognised by their families and staff?

Table 1: Research questions

This section reviews the research questions presented in chapter one and repeated above. The subsidiary questions are systematically reviewed to understand the core research question, which is addressed last.

7.3.1 Subsidiary questions

I) The evidence from this study is complementary to previous studies (Gutman et al., 2018; Harriss, Barlow, et al., 2008; Price et al., 2017) which highlighted that the therapeutic approach offers a range of benefits to children and their families.

Principally, these benefits include the children's academic, social and emotional progress. Consistently, the findings suggest that throughout the therapeutic placement, children benefit from being able to recognise their own feelings and those of others, developing a stronger sense of self and awareness of their feelings. This enables them to develop and maintain relationships with families, peers and staff members, something all the children had found

extremely difficult before attending the MBS. This development of relationships further supports children's progress, allowing them to participate in groups and positively impacting their learning. A further benefit of the awareness of their feelings is significant improvements in behaviour, with all children reducing their levels of aggression and antisocial behaviour.

For the families, the therapeutic approach offers not only a residential placement, providing respite from the emotional, and often physical, impact of the children, but an opportunity to make sense of the relationships within the family, and of how events led to a residential placement. Although this benefit appeared hard to articulate, the evidence strongly suggests the therapeutic approach benefits relationships between children and their families and peers; significant improvements in behaviour were seen in home settings, evidenced by the children's improved self-regulation and significantly reduced aggression and antisocial behaviour.

Despite the benefits offered by the therapeutic approach, numerous limitations have been identified. The work of the school focusses on enabling children to become aware of their feelings and the impact of these on their relationships and behaviour. Through projection and the children's behaviour, staff have to carry and process many of these feelings for the children, often in times of distress and in conjunction with managing their own emotions. The opportunities for reflective practice appear to go some way towards enabling staff to process and make sense of these emotions and the resulting dynamics that arise, but the emotional impact is still significantly challenging for many staff.

One of the most unexpected findings was the sense of 'not knowing' from those in direct contact with the children. This appeared to mirror the children's backgrounds, the model of group work and the definition of 'therapeutic', and represents an unconscious defence against the children's trauma, appearing powerfully to create an emotional distance between staff and the children's trauma.

II) The group-work model is core to the MBS's work (Diamond, 2009; Dockar-Drysdale, 1968; Staines, 2017), utilising a core concept of therapeutic communities to enable children to make sense of their emotional responses as a means to developing relationships with others. Despite participants identifying that children's involvement in groups impacted their ability to develop relationships, the use of group work was inconsistently understood by participants.

There existed significant confusion about the difference between formal and informal group spaces. Moreover, despite senior staff articulating the group-work model, it was not clearly operationalised by staff. Families and staff experienced uncertainty about the therapeutic function of groups, influenced by their anxiety about whether their child could self-regulate within a group and manage being a group member. The majority of participants considered that the child's ability to be part of a group increased as the placement progressed, leading to increased participation within family 'group' settings.

As placements progressed, participants developed a clearer understanding of what group experiences the children were part of, though there still existed confusion about the therapeutic function, particularly of formal group spaces. There exists a strong correlation between children's ability to be part of a group setting and their ability to understand their feelings. This was understood to be a direct response to the use of groups to recognise and discuss emotions, subsequently leading to children's increased ability to develop and maintain relationships with peers, families and staff, and, importantly, to make changes in their behaviour.

However, despite the evidence suggesting children's use of groups linked to improved behavioural outcomes, the evidence suggests there remains a high level of avoidance of group situations among children and staff alike. This possibly reflects an avoidance of the

emotional impact of the group at an unconscious level, perhaps as a defence against the overwhelming projections within the group.

III) The final subsidiary question refers to how changes in children's behaviour were recognised by families and staff. On the surface, there was a shared response which recognised that, as a result of the MBS's therapeutic placement, children's behaviour significantly improved, with reduced levels of aggression. Non-compliance and antisocial behaviour were named as the primary changes.

However, beyond these changes, several points were identified. Prior to the MBS, the children's behaviour had been so difficult that their families and previous placements had been pushed to 'breaking point', hence the need for a residential placement. At this point, the impact, both physical and emotional, of the children's behaviour was such that it took precedence over their emotional needs. Children had limited awareness of their feelings and behaviours, resorting to 'fight-or-flight' impulsive behaviour as a defence against their feelings, and particularly against relationships which failed to provide them with emotional containment.

Families noted a significant positive change in their dynamics as a result of the changes to the children's behaviour. This led to reduced tension in households, increased confidence to take the children into social environments and longer-term improvements in family dynamics for three of the four children. Families noticed physical changes to their children, highlighting more stable heart rates, suggesting an improved sense of self-regulation and an increased ability for the children to manage their frustrations without resorting to 'fight-or-flight' responses.

Unlike the development of relationships, the research highlights a gender-based difference relating to the pace of behavioural change: girls appeared to make positive changes more quickly than boys. While the girls appeared more aware of the emotional containment provided by staff members, placing emphasis on child-to-staff relationships, the boys made greater reference to the need for physical containment by staff members, particularly by male staff. However, staff highlight the containing function of relationships for both boys and girls.

Alongside these behavioural improvements, there appeared to be a split between the MBS and the home environment, with a view that positive behaviours were prevalent at home, or more noticeable outside of the group environment. This particularly related to reduced aggression, which for some children completely ceased. Families and staff also noticed the children's increased awareness of their feelings and the ability to recognise and talk about them, which was directly linked to improvements in behaviour, as highlighted below.

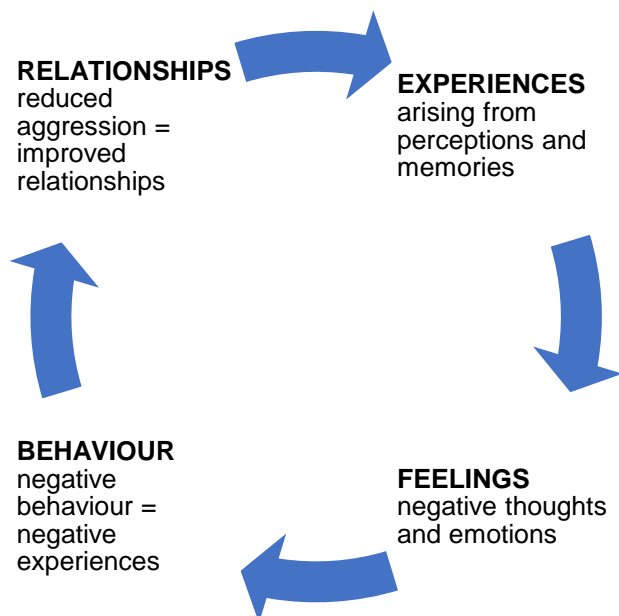


Figure 5 : How experiences impact feelings, behaviours and relationships

All participants noted significant improvements in children's peer relationships, with some suggesting that this was the first time the children had experienced 'real friendships'. As the placements progressed, the children presented with less of a 'false self', highlighting an increased sense of self which corresponded with their developing peer relationships and improved behaviour.

Although families and staff identified significant positive changes to the children's behaviour, several less positive changes were also identified. The nature of children moving from home to a residential placement with a focus on emotional relationships led to an increased awareness of guilt and shame, felt by both children and families. In addition, some children developed new behaviours that were initially considered negative – for example, increased swearing. However, despite these being viewed by families as negative changes, staff recognised them as more positive examples of the children developing a sense of self.

7.3.2 Overall case

By reviewing the subsidiary questions, the research concludes that the MBS significantly affected the lives of the four children who participated in this study. It is not possible to generalise to all emotionally traumatised children in its care, but it should be considered that the findings of this study may relate to the other children. Most notably:

- The therapeutic milieu enables the children to become more aware of their emotional states and their own feelings. This, in turn, supports their ability to develop and maintain relationships.
- The development of relationships enables the MBS children to make greater use of the school's therapeutic provision, including the use of groups, which supports the children to develop their capacity to understand and regulate their feelings.

- There is an agreed consensus among all participants, which supports previous research, that children make good academic, emotional, behavioural and social progress at the MBS.
- Even if children's pre-placement behaviour overshadows their therapeutic needs, once they can make sense of the therapeutic milieu, they make significant progress.

The study highlights a number of areas within the therapeutic task that were initially felt to be unclear. The findings suggest a considerable lack of clarity about the detail of the therapeutic approach and the use of group work. While some of these areas – for example, the role of the family in the therapeutic approach – appear to be poorly understood, other areas – such as the overall therapeutic approach – are both poorly understood and act as an emotional defence against the overwhelming impact of the children's trauma. This offers the MBS a series of learning and development opportunities.

7.4 What does the study offer the MBS and the therapeutic childcare sector?

The research thesis makes a significant contribution to the literature concerning residential therapeutic childcare by providing an in-depth case study in the childcare sector, which is often under-represented and unclear. The thesis argues that, with a growing number of children experiencing emotional early-life trauma and becoming looked after children, models for addressing children's abilities to understand their feelings and develop relationships are paramount, yet still wanting. Through the development of relationships, it has been shown that children allow others to support them, leading to reduced antisocial and aggressive behaviours. This, in turn, leads to increased involvement in group settings, including class environments, thus leading to increased opportunities for learning.

These insights can be used to develop links between theory and practice, developing practice not only within the MBS but more widely. This should be linked to practitioner training across the sector, which, as highlighted in chapter two, is considered inconsistent and failing to match the complex needs of the children. The study highlights the importance of recognising the unconscious communications from participants and the need for these to be considered as communication. As such, the training and support of professionals working with early-life trauma, whether in a residential setting or not, require consideration. They need to be designed in a manner to enable practitioners to develop these skills. The existing training, whereby practitioners 'evidence their childcare knowledge', is insufficient and potentially detrimental to those with complex needs.

The MBS would benefit from reviewing how its model of practice is communicated to staff and the organisational defences which may inhibit this being clearly put into practice. There has been a significant amount written about the model, and this is articulated at a senior level but not across the organisation. In addition, work is needed to develop a shared understanding of the expectations of therapeutic placements and how these link to placement objectives. The differentiation between MBS departments in this area would benefit from further consideration.

In addition, the MBS would benefit from reviewing the information given to parents and foster carers prior to children commencing their placement. This would then require follow-up work to ensure they fully understand the nature of the therapeutic placement, and the expectations on the children and themselves.

The study highlights the need for organisational and practitioner awareness of the impact of individual and organisational defences, which are linked to the children's early-life trauma. Attention should be given to the issues of 'confusion' and 'not knowing', whether these are genuine phenomena or representative of something more unconscious, as argued in this

study. Further exploration could significantly develop the understanding of the emotional impact on staff and families working with complex trauma. MBS staff training could address these points, but this alone will not overcome the organisational defences that limit the shared understanding of the model.

7.4.1 Implications for further research

This study has focussed on the impact of the therapeutic approach on the children while at the MBS. A valuable follow-up study would be to follow these children's journeys from the MBS to their subsequent secondary placements and beyond, to identify how the therapeutic impact of the MBS has been internalised and affected their longer-term outcomes – for example, whether the MBS impacts their ability to gain qualifications and employment and develop relationships, or whether children who have attended the MBS have lower levels of mental health and criminal justice interventions than other children who have experienced complex trauma.

Consideration should also be given to designing and implementing a study focussing on parents and carers. This might examine their perceptions of how other professionals see them and the subsequent impact on the children. This would provide a much-needed additional component to understanding the wider systemic work of the MBS, building on the 'shared parenting' research undertaken by Onions (2017a) within the school.

This study has focussed on a small number of children who have experienced complex trauma, requiring a therapeutic residential placement. Given the evidence for therapeutic work affecting such children, consideration should be given to how elements of such therapeutic models, particularly a group-work model, could be applied to other settings and impact a greater number of children – for example, in mainstream schools. This is not to

suggest a replication of the MBS's intense therapeutic model, but a review of how the ethos, values and individual models could benefit other settings.

There are implications for the wider therapeutic childcare sector in its use of language and whether a more consistent understanding of therapeutic work could be developed among childcare professionals. For example, the inconsistent understanding of the term 'therapeutic' means placements are not consistently matched to the needs of the children by placing professionals or families, placing an additional barrier in the way of working with the children and their families. Consideration should also be given to whether children from birth families retain an unconscious ability to form stronger peer relationships as a result of having fewer placements.

7.5 Limitations of the study as a whole

A number of limitations require acknowledgement. Previously, I referred to the development of my thinking throughout the study and how this impacted the study. While this was a positive outcome, it also meant that aspects of the fieldwork could have been undertaken and developed in different ways. Specifically, had I recognised the high number of defensive responses I would receive at the start, I would have used an essential line of enquiry during the interviews. Subsequently, this may have given greater insight into the impact of these defences and how they might differ between stakeholders. Additionally, this could have led to a slightly different focus for the literature review: the psychoanalytic research of trauma defences.

Chapter three's methodology analysis looks in detail at the limitations of the different data collection and analysis models used throughout. This includes the potential struggle to balance my dual role in the MBS and the impact of my being an 'insider-researcher'.

Although several advantages to this are recognised, there is the potential for over-familiarity, leading to a lack of objectivity. Furthermore, given that much of this study relates to unconscious processes, I have recognised throughout the study that my prior knowledge of the MBS could have led me to, unconsciously, make ‘wrong assumptions’ and thus introduce a form of bias (Unluer, 2012).

A further limitation was the small sample size. Although this made the study logistically feasible, a broader study would have been beneficial. Throughout the data collection, I was fortunate to have the opportunity to hear the life stories of the children and their families and the perspectives of the staff teams. Although considerable time and effort were given to identifying themes from these recordings, a more thorough analysis would have benefitted the study. For example, from a methodological perspective, it would have been beneficial to moderate the coding of the transcripts with a team of peers, and for the findings and analysis to be peer reviewed.

To enable the project to remain manageable, it was necessary to establish clear boundaries around the collection of research data. In chapter three, I gave the reasons for selecting a sample of four children as embedded cases, and how this would allow for the building of an overall case: the MBS. I have outlined the reasons for focussing on the development of relationships and the use of the group-work model, while recognising that a broader study with a larger sample size would be beneficial.

A further limitation of the therapeutic approach is the emphasis placed on staff–child relationships in relation to the development of secure attachment figures. To achieve this requires an engagement with the emotional inner world of the child, yet this has a significant emotional impact on staff, leading to defensiveness against such relationships. Additionally, this emotional impact appears to relate to staff turnover, meaning new staff and new relationships being developed – a particular issue for one of the children in the study. The

issue of gender is only briefly touched upon, and given that the sample size consists of two boys and two girls, a broader and possibly comparative study might offer an alternative explanation for the impact gender has on the effect of the MBS's therapeutic approach on children.

Since the commencement of the study in 2013 and its completion in 2020, the MBS has completed a seven-year longitudinal research project and seen the publication of Onions' (2017a) doctoral study. Furthermore, the initial findings from a second qualitative study into the impact of reflective practice were shared within the school. In hindsight, it would have been beneficial for these studies to be more closely aligned at the design stage of this research. Nevertheless, this study complements these studies and helps to provide a broader understanding of the experience of living in a residential therapeutic childcare setting. Furthermore, while I have aimed to keep abreast of new publications throughout this study, I reached a point where I needed to 'stop reading' and 'start writing', so new texts may have helped to develop progressive and contemporary insights.

Finally, although I recognised the issue of children residing with either birth, foster or adoptive families, this has not been explored in depth. This issue warrants further research within the school to explore the impact of the home environment and pre-placement attachments on the child's ability to make use of the therapeutic approach.

7.6 Researcher reflexivity and the contribution to theory

Throughout this study, one of the most prominent issues has been my role as an insider-researcher and how this has impacted not only the research, but my role as an academic and as a researcher. The advantages and disadvantages of insider research have already been discussed (see chapter three), but it is important to recognise how these link to

researcher reflexivity. Researcher reflexivity is defined by Gibbs as 'reflection upon theories, thoughts, feelings, actions, interpretations, assumptions, expected and unexpected outcomes and the development of practice and theory from further reflection' (2001, p.697).

Reflection has been a central component of this study and a core principle of the MBS's therapeutic approach. The requirement to reflect on my role as an insider-researcher has been challenging and provocative. Throughout the study I have been forced to review my assumptions of myself and others, and to look at findings which have challenged me to remain in my role as a researcher rather than an MBS employee. However, as a result of this personal realisation, the research process is felt to have been more rigorous and the construction of knowledge significantly improved.

The construction of knowledge has led to this study making a significant contribution to understanding and implementing the theory of the MBS's therapeutic approach, influenced by theories relating to approaches to childhood trauma. In turn, this will inform the wider therapeutic childcare sector, offering increased insight into the needs of children who have experienced early-life trauma, their families and the staff working alongside them.

7.7 And finally...

The study maintains that the extreme exhibition of trauma results from a combination of emotional insecurity and repeated failure of relationships. To address this, we need to observe a wider shift across the childcare sector – not just in the MBS or the residential sector – away from professionals asking the child 'What is wrong with you?' and towards asking 'What has happened to you?' This will allow professionals to see beneath the surface, to look at the unconscious communications children exhibit through their behaviour. However, this will require an increased awareness of the emotional impact on staff of working with complex trauma, and the unconscious defences against such an impact.

As Leo's mother highlighted, 'I don't know what the school has done, but they've saved my family'. This sentiment exemplifies the research findings: that significant progress is made by children, but that it is not always clear how this has been achieved. Perhaps by delving deeper, overcoming our defensive responses and making sense of some of the 'not knowing', the therapeutic model can be further adapted for other settings, benefitting a greater number of children and their families.

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Appendices

Appendix 1 Information sheets



Dave Roberts – IoE / UCL Researcher

Tel: 07530 421076

Email: droberts@mulberrybush.org.uk



Information Sheet

“How are children at the Mulberry Bush School supported to develop relationships?”

I would like to ask for your support in a research study I am completing for my doctoral thesis at the Institute of Education / University College London. This sheet will provide you with information about this study and what it will involve. This is important in helping you to decide whether you would like to participate. If you would like to know more or have any questions please feel free to ask. My contact details are above.

What is the purpose of the research?

The purpose of this study is to explore the benefits of a therapeutic environment for the children placed at the Mulberry Bush School. There is currently very little research exploring the views of children, parents, carers and professionals in relationship to how therapeutic school can support children’s relationships. I believe that this research can help the Mulberry Bush, and other professionals, develop a better understanding of how to support these children.

Although this study is being undertaken independently of the Mulberry Bush School it has the full support of the school’s management and trustees.

Who is doing the research?

The research is being undertaken by myself, Dave Roberts under the supervision of Dr John Vorhaus at the Institute of Education / UCL in London. As you may already know I am the Head of Training at the Mulberry Bush and have worked in residential childcare for almost 25years.

Do I have to take part?

Involvement in the study is voluntary and I would like to emphasise that your child’s placement at the school is in no way connected to participation in the study. If you are happy for your child and yourself to participate you will be asked to sign a consent form which will indicate that you have read this information sheet, agree to take part and are aware of your right to withdraw at any point.

What is involved?

My aim is to involve children, parents, carers and school staff to develop a deeper understanding of the impact of the therapeutic environment on the children. The study will commence in summer 2015 and run through to 2018.

If you agree, the study will involve XXXX talking with me three times during 2016 about their experiences of the Mulberry Bush, and more generally about their life. This discussion will be audio-recorded and take place at the school and should last for no more than 30minutes. The recording will be transcribed and kept by myself, it will not be shown or shared with anyone else.

I would also like to talk with you about your experiences of the school, again for about an hour. Ideally I would like to meet with you at the start and end of 2016. This could be at your home, at the school or somewhere else that suits you – you can choose.

Part of the study will involve following what happens to two of the children after they leave the Mulberry Bush. As part of the consent form you will be agreeing to me potentially talking to your child's next school approximately three months after they leave the Mulberry Bush.

What will happen to the information?

Your personal information and comments made during discussions will be made anonymous and will not be shared with anybody else. The information will only be used for the purpose of this research. Some direct quotes may be used in the final report but no names will be attributed to these in order to maintain your confidentiality. Pseudonyms will be used for all participants to support confidentiality and anonymity.

Detailed study notes will be kept by myself but, again, will not be available for anybody else to see. The final report will be shown to you, and a child friendly version to your child, before publication, which is expected to be in 2018. The final report will be published as a thesis and extracts will hopefully be published in journals.

Due to direct quotes being used parents, professionals and children should be aware that parts of the final report may be emotive and raise difficult feelings.

Does the research have ethical approval?

The project has already received formal ethical approval from the university's ethics committee but if you have any questions please feel free to contact me or I am happy to meet with you when you are next at the school.

I will not speak with XXX about this until I have heard back from you.

I look forward to hearing from you,

Dave Roberts

February 2016



Independent IoE/UCL Research Project
at the Mulberry Bush School

PARENTAL CONSENT FOR CHILD'S PARTICIPATION

Please reach each statement and tick the box if you agree:

I confirm that I have read and understood the information sheet dated Sept. 2015.

The purpose of the study has been explained to me and I have had the opportunity to ask questions. I understand what the study will involve.

I understand that every effort will be made to provide anonymity but that this may be limited due to the small size of the Mulberry Bush School.

I understand that my child's involvement in this study, and any information they provide, will remain confidential and will only be accessed by the researcher.

I understand that I have the right to withdraw at any point during the study.

I agree that the researcher may contact my child's subsequent placement and discuss their placement.

I agree / do not agree (please circle one response) to my child's participation in this research study and am happy to be interviewed myself as part of this research

Name of child: _____

Your Name: _____ (parent/carer)

Signed: _____ (parent/carer)

Date: _____

Please return this reply slip in the pre-paid envelope to the school no later than Wednesday 24th February 2016, thank you.

Mulberry Bush School
Standlake
WITNEY
OX29 7RW
Tel: 01865 300202 ext.241
Email: droberts@mulberrybush.org.uk

Dear XXXX (professional)

Re: Name of child concerned / D.O.B

I would like to ask for your support in a research study I am completing for my doctoral thesis at the Institute of Education / University College London. The purpose of this study is to explore the benefits of a therapeutic environment for the children placed at the Mulberry Bush School.

Although I am currently employed at the Mulberry Bush this study is being undertaken independently of the school and has the full support of the school's management. My aim is to involve parents, professionals and the children themselves to develop a deeper understanding of the impact of the therapeutic environment on the child and how this may benefit children into the future. The study will commence in summer 2015 and run through to 2018.

If you agree, the study will involve my talking with children, their families and professionals such as yourself about the child's experiences of the Mulberry Bush, and more generally about their lives, throughout their placement at the school. All discussions will be audio-recorded and can take place at the school, the family home or other suitable locations.

Involvement in the study is voluntary and all participants will have the right to withdraw at any point during the study. I would like to emphasise that there is no correlation between the child's placement and participation in the study. All personal information and comments made during discussions will be made anonymous and will not be shared with anyone. The final report will be shown to participants prior to publication, which is expected to be in 2018.

If you have any questions, please feel free to contact me at school or via my email as indicated above or I am happy to meet with you when you are next at the school.

Yours sincerely,

Dave Roberts

I agree to my participation in this research study **Yes / No** (*circle as appropriate*)

Childs Name _____

Your Name _____ Professional Capacity _____

Signed _____ (Professional) Date _____

Please return this reply slip in the pre-paid envelope to the school no later than Wednesday 1st July 2015

How does the Mulberry Bush School help Children?



Hello

My name is Dave Roberts and you may know that I work at the school. As well as working at the school I am also a student at university and am doing a really big piece of research. My work is about what children think about being at the Mulberry Bush School.

I would like to ask if you and your family would please help me? I would really like to hear about what you think of the school and whether it helps you, and if so how.



If you and your family agree then I would like to spend some time talking with you every few months whilst you are at the school. Our talk would be private and I will not tell your family what you say.



Each time we meet it will be for no more than one hour. You can ask to stop at any time.



You can say yes or no. It is up to you whether you take part.



If you would like to talk to me about the project please get one of your grown-ups to ask me. You can even ask them to join the discussion if that would help. When you have signed this form please give it to one of your grown-ups to give back to me.

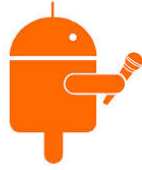
Thank you for taking the time to read this letter and for your help.

From

Dave Roberts

If I talk to Dave Roberts about his project “*How does the Mulberry Bush help children?*”

- I understand that the talks will be recorded.



- I understand that the talk will be private.



- I understand that I can stop talking with Dave at any time.



If you understand the statements above, you now need to decide whether you would like to take part in the project.

I have decided that I would like to talk to Dave about his project “*How does the Mulberry Bush help children?*”

Please put a circle round No or Yes.



No



Yes

Signed.....

Please print your name.....

Interview questions for children:-

The pilot highlighted that the number of questions was too many and suggests that a theme for each of the three sessions would be more helpful.

Session 1 – Theme - history/engagement “When you arrived” (Develop a timeline that can be returned to in future interviews)

1. What do you like to be called?
2. How old are you now?
 - a. Can you remember how old you were when you first came to the Mulberry Bush?
(number cards to be used)
 - b. Can you remember how you felt when you first came here? Can you tell me a little bit about it? *(children may need to be given a range of emotion cards to help identify how they felt)*
3. c. Can you tell me a bit about the time before you came to Mulberry Bush? [probe]
 - a. What can you remember about this time? [probe]
 - b. Did you find it easy to make friends? [probe]
 - c. Where did you live? Who with?
4. Can you tell me about how you got on with people before coming to the Mulberry Bush – for example your friends/family/staff?
(children to mark on a scale how easy/difficult - for each category encourage them to say a bit more)
5. Why do you think you came to the Mulberry Bush? Did anyone talk about this with you? [probe]
What did it feel like coming to the school? [probe]

Session 2 – Theme is ‘here and now’ (use & develop timeline from session 1)

1. Can you tell me about how you get on with people, your friends/family/staff?
(children to mark on a scale how easy/difficult - for each category encourage them to say a bit more)
 - a. Do you sometimes argue or fall out with people? [explore]
 - b. Are there things or people at the Mulberry Bush that help you with this? [explore ‘things’ and ‘people’ and how for each of these, in detail]
 - c. Do you think being at the Mulberry Bush has helped you get on with other people? [explore]
2. What sort of groups are you part of at the school? What do you do in these groups? [get detailed description, and probe re what they think about working in groups]
3. Do you think being with other children like you has helped you at all? Can you tell me why you think this?
 - Is it helpful living with some of these children and going to class with them? [probe re in what ways]
 - Has being with other children like you helped you be more confident (**may need to define this to child**)? (to mark on 1-10 scale)
 -

Session 3 – Theme is ‘where next/hopes for the future’ (use and conclude timeline)

1. When we talked the last time about how you get on with friends/family/staff, this is how this is how you showed it on the scale. Do you think this will be different by the time you leave the school? [probe]
 - a. What would you like to be different about how you get on with others when you leave the school?
2. Have your behaviours (positive and negative) changed since being at the school? Can you tell me a little about this? How would you like this to be by the time you leave the school?
3. Where do you think you will go after the Mulberry Bush?
 - a. Is this what you would like?
 - b. Are there things you need to change to achieve this?
 - c. How does the school help you with this?
4. Is there anything else you'd like to tell me about being at the Mulberry Bush? Is there anything at Mulberry Bush that you would like to change?

Interview questions for parents:

The pilot suggests that these questions are appropriate but are perhaps too many and prevent fluid conversation. As with the children it is proposed that the two sessions have slightly different themes

Session1 – Theme – what happened before the Mulberry Bush and now

1. What is your full name and your relationship to X
2. Can you tell me a little about living with X before the Mulberry Bush?
3. Why do you think he/she went to the Mulberry Bush?
 - a. How do you think he/she would answer that question? Probe
 - b. How was the therapeutic nature of the school described to you? (probe) – **FROM LIT REVIEW**
5. What do you remember about him/her starting at the school?
6. From things you've seen and what s/he's told you, what you think they experience as the best things about the Mulberry Bush? [probe and ask for examples]
 - a. And the things that are not so good?
7. How has the placement of X at the Mulberry Bush affected [probe for each]
 - a. Yourself and your family?
 - b. Your child
 - c. Anyone else?
8. Can you tell me about how X gets on with other people – family/friends/new people? Can they make and sustain relationships?
 - a. before they went to Mulberry Bush?
 - b. Now?
 - a. How do they used to get on in group situations? Have you seen any difference now?
 - b. Do you think being at the Mulberry Bush has affected how they get on with other people? [explore with examples]

Session2 – Theme – now and into the future

1. When we met last time we spoke about how X got on with other people and you were saying.....
 - a. That was X months ago, Can you tell me about how they are getting on now with other people – family/friends/new people? Can they make and sustain relationships?
 - b. How do they get on in group situations?
 - c. How do you think being at the Mulberry Bush has affected how they get on with other people? [explore]
2. Do you think being with other children like him/her has helped? Can you tell me why you think this?
 - a. Have you seen a change in their behaviour, attitudes and confidence since being at the Mulberry Bush?[probe]. What are the changes you have observed? What aspect of the schools work do you feel has supported these changes to occur?
 - b. You may be aware that the school uses group work as its therapeutic approach – how do you think being in a group has helped X? [probe] FROM LIT REVIEW
3. Do you think X will be different when s/he leaves the Mulberry Bush? [probe]
 - a. When X leaves the Mulberry Bush where do you think they will live/go to school?
 - b. Do you feel they are equipped to leave the school and live/be educated elsewhere? (EXPLORE)
 - c. What would you like to be different?
4. Is there anything else you'd like to tell me about X being at the Mulberry Bush?
5. Is there anything at the Mulberry Bush that you would like to change?

Questions for staff

Session 1 – Theme – getting to know the child

1. How would you describe X and the reasons they came to the Mulberry Bush?
 - a. How do they understand why they came to the school?
2. Are they able to develop relationships with children/staff and their family? [discuss]
3. How would you describe their ability to be part of a group? [probe]
 - a. How does this impact on their confidence?
4. What are the key behaviours that X presents?

Session 2 – Theme – progress

Start with brief recap from last session

1. Use of group
 - a. Has their ability to be part of a group changed? If so how?
 - b. How has this impacted on X
2. Since we last met, Y months ago, what (if any) changes have you seen with X?
 - a. How have their relationships changed? [probe]
3. What are the key behaviours that X presents?
 - a. Has this changed? [probe]
4. In light of what we've discussed, are there any changes you might like to see in the supports provided to children at Mulberry Bush?

Appendix 4 Interview time frames

Month	A	B	C	D	E - reserve 1		
CONSENT							
ND - withdrawal							
AG SM CV MD							
September	Archive review - ND				1		
October		Interview 1	Archive review			2	
November		Parent Interview	Interview 1	Archive review		3	
December		Focus group with staff	Parent Interview	Interview 1	Archive review	4	
January			Focus group with staff	Parent Interview	Interview 1	3	
February				Focus group with staff	Parent Interview	2	Archive
March			ANALYSIS		Focus group with staff	2	Interview 1
April			Interview 2	ANALYSIS		1	Parent Interview 1
May				Interview 2	ANALYSIS	1	Focus group with staff
June					Interview 2	1	ANALYSIS
July			ANALYSIS	ANALYSIS	ANALYSIS		Interview 2
August		SUMMER BREAK FOR CHILDREN, STAFF AND FAMILIES					
September						1	ANALYSIS
October			Interview 3				2
November		Parent Interview 2	Interview 3			3	
December		Focus group with staff - 2	Parent Interview 2	Interview 3		3	
January		ANALYSIS	Focus group with staff -2	Parent Interview 2		2	Interview 3
February			ANALYSIS	Focus group with staff - 2		1	Parent Interview 2

TRANSCRIPTION OF INTERVIEWS

March

ANALYSIS

Focus group with staff - 2

ANALYSIS



Appendix 5 Descriptive phenomenology - significant statements and their formulated meanings

Below is an extract of an interview transcript's significant statement and the formulated meaning derived from these, with identifying page and line numbers.

Statement no. (J)	Extract of significant interview statements	Formulated meanings
131	He liked spending time with – it changed when Wendy came, because then they had the sort of love story and that was a bit different. But he liked spending time with Nadine and Sacha, so he quite likes younger both girls, probably very non-threatening children. (J.	liked spending time with the girls, who he sensed were non-threatening
132	here were times when I felt he was very false and I found him slightly repulsive and a bit, not quite creepy but there was something that made me slightly uncomfortable. I always felt like I was waiting for him to blow and he never did. I always felt like that was coming.	sense of false, could be creepy, made staff uncomfortable
133	Then, we get to half-term, where he refused to leave the house. There's a suspicion that part of that is because of, "Outside isn't such a nice place," and he can't even leave his front door without, potentially, coming across Ben. Any demand or request for him to leave the house...	child refused to leave family home during holiday, outside wasn't nice/friendship broken down
134	Yes, he loves being with other children. He never liked having his education away from other children. He likes the security, he likes the fact that you all know how to deal with children like him. I mean, just the fact that he's-	Likes security of being with others, likes knowing staff can deal with him
135	I mean, he will play with other children, but he hasn't got any close friendships.	Child can play but no close friendships
136	Yes, and he waited until 3:00, and then he was out there, "Is there anybody there for me to play with?" So, he has got children that he plays with on the estate that we live in.	Has friendships at home, wants someone to play with

- 137 He'd let everybody play with his go kart. I don't think it's changed, but I think the relationships are still there. I've had to fish him away from some of the ones... I leave them out there, but I will check frequently, because I think he needs a bit of space without me hanging around all the time, but I'm worried about... You know, one person who says one wrong thing, and he's going to flare up. He has got into situations where he has hurt other children on the estate, so we need to check frequently that he's okay, and I do that
- Has friendships at home, can share go-kart with others, can be left with them having space. Mum is worried what happens if someone upsets him, can hurt other children
- 138 So F is particularly his friend. He did fall out with B, his friend on the estate, during the summer holidays. He got very angry one day, and B was trying to stop him from running away, and he kicked and punched B, and then after that B didn't want to be friends with him anymore,
- F is a friend, child fell out with B in summer after getting angry when B tried to stop him running away. Became aggressive, B no longer wants to be friend
- 139 He says he really likes it here. I think he likes having lots of other children to play with all the time, and I think when he goes home he misses that, and wants to have other children to play with. I think educationally he's been engaging with his learning, apart from the last term when he was all over the place. Generally speaking, he's making good progress academically, which he wasn't before.
- Child says he likes MBS, likes being with others children – can miss that at home. Engaging with learning, except last term – making progress now
- 140 Well, it's the way the staff relate to him, and encourage him. They have firm boundaries, but they encourage him to meet targets. It's the staff that make the difference. It's people that make the difference to other people. You could have the systems in place, but if you don't have staff who actually know how to relate to children, who know how to be firm, who have the emotional capacity to be able to love them and care for them in the right way, then all your systems will come to nothing.
- Staff make difference, they relate and encourage, have firm boundaries with child. Not about systems, but need people with emotional capacity to love and care
- 141 I think he's developing a relationship with his new care-worker here. I think once he's adjusted to the loss of M. leaving..
- Child is developing relationship with new key-worker, adjusted to loss of previous worker

142	I believe it's because when he loses somebody important to him, it taps into the losses he's already had, and brings up the emotions that he felt when he lost his birth mum. We've seen that time and time again in the past anyway, but it's happened again here. In a way, I'm glad that it has been seen here, because if he just did everything perfectly, then that's not the JAMIE that we know. There are two sides to JAMIE.	Repeatedly, when child experiences loss it reminds child of loss of birth mum. Two sides to child, glad staff have seen both.
143	I also think he knows that if he hurts us we'll stop him, and that may be in itself enough for him to control it. Yes I think he has a sense here that he can't bully grown-ups to get his own way.	child knows staff can stop him hurting, has sense he can't bully
144	"Who's it going to be?" Who's he going to be able to have that chat with? At times, he seems to be getting closer. Sometimes, he feels so dangerous and violent	Child closer to emotions but can be dangerous, who can he talk to?
145	One of his targets a while back was to let adults tell him when enough was enough because he would just eat so quickly and so much food. He was achieving all the targets and doing really well, but, interestingly, in the last few weeks, he's eating really fast again, and he's been helping himself to stuff off the side and stuffing it in.	Child can function towards targets, can let adults put in boundary around food. Capacity for this has recently reduced.
146	It is maybe around the loss of relationships that the key worker, E, and the teacher have done or the realisation that, actually, he's developing a relationship, having been a year?	Child understanding they are creating relationships, staff helping child
147	He never spoke about being homesick, but he did make stuff for his parents. So certainly at times, there are a few times I would go in and he'd made pictures or like arts and crafty stuff, that he made specifically for mum. So he was obviously thinking about them and that was quite important to him that he had made stuff.	child didn't appear homesick, would make things for parents, specifically for mum

Appendix 6 List of codes

1. Am I the only person who is doing this?
2. Before MBS
 - a. behaviours
 - b. child diagnosis
 - c. family diagnosis – history
 - i. home
 - d. initial concern - LAC
 - e. Interventions
 - f. previous schooling
 - g. siblings
 - h. significant events
3. Curiosity
4. Education
5. Groups
 - a. In groups
 - b. not in group / unclear
 - c. can contribute to groups
 - d. cannot contribute to groups
 - e. model clear
 - f. model not clear
6. Impact of MBS
7. Impact on family
8. Management view
 - a. anything else
 - b. behaviour 2
 - c. effectiveness
 - d. features & aims 2
 - e. groups 2
 - f. if only....
 - g. Progress 2
 - i. families
 - h. relationships 2
 - i. why MBS
9. MBS behaviours
 - a. Aggressive
 - b. Fight / flight
 - c. anxious
10. Perception of self
11. Post MBS
12. Relationships
 - a. post MBS
13. Start audio
14. Therapeutic
 - a. arriving at MBS
 - b. feelings
15. timing of placement
16. why attend MBS
17. what else could be offered by MBS
18. being at the school
 - a. progress at MBS

Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ... Swear at you, insult you, put you down, or humiliate you? **Or** Act in a way that made you afraid that you might be physically hurt?

Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** ...Push, grab, slap, or throw something at you? **Or Ever** hit you so hard that you had marks or were injured?

Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**...Touch or fondle you or have you touch their body in a sexual way? **Or** Try to or actually have oral, anal, or vaginal sex with you?

Yes No If yes enter 1 _____

4. Did you **often** feel that ...No one in your family loved you or thought you were important or special? **Or** Your family didn't look out for each other, feel close to each other, or support each other?

Yes No If yes enter 1 _____

5. Did you **often** feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
Or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?

Yes No If yes enter 1 _____

7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
Or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
Or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes No If yes enter 1 _____

10. Did a household member go to prison?

Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Appendix 8 Mulberry Bush source staff names and positions

John Diamond	Chief Executive Officer
John Turberville	Chief Operating Officer
Mike Staines	Deputy Head of Group Living
Caryn Onions	Head of Research
Richard Rollinson	Chair of Trustees
Jennifer Browner	Head of Therapies and Networks Team (TNT)
Oliver Klott	Deputy House Manager

Ethics

In this thesis I explore whether a therapeutic environment supports severely traumatised primary aged children to develop relationships with their families, peers and professional staff. The identified therapeutic environment is the Mulberry Bush School (MBS), a therapeutic residential non-maintained school, where I have been employed since 1998. The school provides care and education for children, aged five to twelve years, who display severe emotional or behavioural difficulties, often resulting from traumatic experiences in their early years. The school has been at the forefront of the therapeutic child care sector since its founding in 1948, and it continues to be internationally recognised as a centre of excellence. Many of the children have experienced multiple placement breakdowns, in both home and school, before coming to the MBS.

As of March 2013, the child care sector supported over 67,000 children placed in the care of English local authorities, with over half of these placements following evidence of abuse (NSPCC, 2013). It is intended that, by developing an understanding of the nature and outcomes of a therapeutic environment, it will prove possible to identify the benefits to children at the MBS, and to contribute to the evidence base of interventions aimed at improving the lives and education of vulnerable children. The research will contribute to the literature pertaining to therapeutic work with traumatised children, and can be viewed as an example of evidence based research upon which social work methodologies should be based (British Association of Social Workers (BASW), 2012). The work will provide a qualitative and in-depth analysis of a series of cases which will explore how a therapeutic approach may be beneficial to understanding and working with traumatised children. This gives the study overall an ethical purpose. At the heart of the ethical approach to be adopted here is the importance of understanding and exploring the viewpoints of all participants in a manner that is not detrimental to their welfare; and the importance, also, of promoting

amongst participants the sense that they are respected in their own right and are not simply 'objects' for the use of research and researchers (Alderson and Morrow, 2011). The development of a culture within social research designed to be more inclusive of children in the research process has been highlighted increasingly over the last decade (Flewitt, 2005) and is exemplified by the ethos of organisations such as the European Early Childhood Education Research Association (EECERA). This culture links with the ethical frameworks consulted here: the British Association of Social Workers (BASW) code of ethics - my professional association - and the British Psychological Society's (BPS) statement of ethical practice (2009) which will guide this research.

As a professional Social Worker I am bound by the ethical code of practice of my professional body BASW (BASW, 2012). These principles³⁸ within the code provide an overarching framework, highlighting obligations to those with whom I work, in terms of both practice and research. Social work in the 21st century is a dynamic and evolving profession (BASW, 2012), and in consequence any code of practice should be used as a supportive framework. The BASW code is practice orientated and will therefore be used as a source of overarching principles, rather than a research ethics code. As research I will conform to the Code of Ethics and Conduct from the British Psychological Society (2009), a more research based framework. The four BPS principles of respect, competence, responsibility and integrity are closely aligned to the 17 principles detailed by the BASW, thus supporting the concept of BASW providing an overarching set of principles relating to practice whilst BPS

³⁸ BASW – The Code of Ethics for Social Work

Summary of statement of principles:

Acting with the informed consent of service users, unless required by law to protect that person or another from risk of serious harm; assessing and managing risk; providing information; sharing information appropriately; using authority in accordance with human rights principles; empowering people; challenging the abuse of human rights; being prepared to whistle blow; maintaining confidentiality; maintaining clear and accurate records; striving for objectivity and self-awareness in professional practice; using professional supervision and peer support to reflect on and improve practice; taking responsibility for their own practice and continuing professional development; contributing to the continuous improvement of professional practice; take responsibility for the professional development of others; facilitating and contributing to evaluation and research (BASW, 2012)

principles being a more focussed on which the research can be built. Despite being a professional Social Worker it is imperative that as a researcher I align myself research ethics set out by the BPS and avoid, wherever possible, seeing myself as a practitioner.

Any study involving vulnerable children raises a significant number of ethical issues; these are discussed below, including, in particular, questions of consent, confidentiality, anonymity, the role of the researcher and the ownership of data.

Consent

The issue of consent is significant at many levels in this research, with overall consent for the study being granted by the management of the MBS. Both ethics frameworks underpin the issue of informed consent, with the BPS core principles of respect, competence, responsibility and integrity lying at the heart of any attempt to support vulnerable children to engage with this study.

Consent will be considered from the perspectives of the children, the families, Mulberry Bush staff and associated professionals, and consent documentation will be tailored to each of these groups. Participants will be asked to 'opt-in' to the study rather than 'opt-out'; the former is likely to be more time consuming and have a lower response but is more respectful and encouraging of free choice (Alderson, 2004).

In order to make consent meaningful informed consent will be sought from only those who are to be directly interviewed, such as foster carers, or who have legal responsibility for any child, such as parents or Local Authorities, and not individuals indirectly involved in the research process. In practice this will mean overall permission will be sought from MBO's Director and trustees, rather than all Mulberry Bush Staff who will be informed of the terms of the research through the production of an information sheet to help gain their support.

Information sheets will also be made available to all children and staff that join after the research commences. It is anticipated that consent will apply for the duration of data collection and will only be required once, though for good practice participants will be reminded of this. The option of participants withdrawing their consent will be explored later.

Under the Data Protection Act 1998 research participants consent to, inter alia, the use to which their data are put and the safe and secure storage of that data needs to be ensured. Participants will be made aware, in writing, of how data are to be stored, held, used and disposed of. Such documents will be made available in simple leaflets accessible to young children and their families (Alderson, 2004).

The children

Article 12 of the United Nations Convention on the Rights of the Child (UNCRC, 1989) stipulates the rights for all children to express their views on matters that affect them, and for 'due weight' to be taken of their views, an issue particularly pertinent in relation to children's consent to medical interventions (Alderson, 1993). Whilst some guidance (for example, guidance issuing from the European Commission 2001), assumes that children cannot give consent, this is challenged by Alderson and Morrow (2011) who state that under English law 'competent minors' under 16 are able to give valid consent. Many researchers, including Flewitt (2005) and Alderson and Morrow (2011) argue that young children are able to ask relevant questions and think through issues relating to consent. For the purpose of this research I adopt the view that the children within the school are all capable of understanding and giving informed consent. In relation to consent it is vital that whilst interviewing children, families and professionals I maintain a supportive, trustworthy relationship, whilst maintaining the professional boundaries (BASW, 2012).

Informed consent can only be meaningful if the children are clear as to what they are

consenting to, and the consequences of giving consent. Consideration must be given to 'how the child thinks'- that is, what the questions will mean to the child. Each child will be given an information sheet, written specifically for children, with pictures to assist with understanding, which makes clear the aims and purpose of the research, what their involvement will entail and their rights to withdraw at any point from any part or all of the research process should they choose to do so. My role will be to ensure these issues are understood by each child (BASW, 2012, BPS, 2009), and with that in mind interview questions will be designed so as to be 'child friendly' in content and presentation. In practice this will mean interviews will be verbally led but also utilise visual aids, creative opportunities to express themselves (Winter, 2011) and verbal cues.

The research will focus on cases of six children at the MBS. Once consent has been given by the child's family and, where legally necessary, the Local Authority, informed consent will be sought from the child. At the start of each interview the child's right to refuse to answer a question, or questions, or to withdraw from the research altogether, will be clearly stated. On-going consent from the children cannot be assumed but will be negotiated throughout the course of interviews and data collection (Simons and Usher, 2000). In practice this will mean the need to respect the fact that children may change their minds over time, or forget what they have agreed to. For good practice discussions about children's consent will need to be staggered throughout the study, depending on the individual needs and understanding of each participating child. This is above and beyond the 'requirement' to only obtain consent at the outset of the research. This practice, grounded in respect for participants, supports children in being informed and in supporting them to form and express views, and it is fully supported by both the BASW (2012) and BPS (2009) frameworks and the UNCR (1989).

Using the National Children's Bureau (NCB) guidelines for research with children and young people (NCB, 2011) as a basis, a checklist has been developed to support what each child

should be informed of when requesting informed consent. This checklist will form the basis of the information given to each child, verbally and in written/pictorial form, and includes:

- The purpose of the research, what is it trying to find out
- Who is undertaking the research
- What will be asked of participants, e.g. Interviews being recorded, anticipated duration and frequency
- How the information will be used and who will have access to it
- What level of confidentiality and anonymity will be given
- How findings will be reported, for example in a written report and publicly shared
- Who will see the final research
- The anticipated benefits of the study to other children and families

In addition, consideration will need to be given to:

- Managing the risks / costs to participants – issues of embarrassment, intrusion of privacy, the fear of admitting anxiety (Alderson and Morrow, 2011). Children will need support at the start to recognise this risk and help them make an informed risk-benefit decision.
- The risk of children feeling 'coerced' into participating or a sense of failure (Alderson and Morrow, 2011)
- The implications of being made aware of possible abuse and the need to report this to other professionals – explored later on.
- The complication of confidentiality when as a researcher I am also a practitioner and member of staff, which will be explored further on.
- The need to maintain confidentiality when different parties ask to view the data.
- Permission to use child's records in research
- Some children may also require additional staff support if they are not selected to participate.

As noted above, children will need to be clear that they can say 'no' to questions or can take a break/pause from the research as well as withdraw their consent at any time. Despite any difficulties for the research following the withdrawal of any child, my first responsibility is to ensure that each child is in a position to make informed choices as they see fit (BASW, 2012). "The welfare of the child" (Children Act, 1989) must be upheld at all costs, no matter what the impact on the research. Alderson (2004) raises the question whether vulnerable participants, such as children, are able to say 'I don't wish to continue'. This issue lies at the core of the study. Sometimes an objection may reflect pain, distress or a lack of understanding, and appropriate reassurance and the development of a relationship with each child is required to support any decision whether or not to continue. Creative and visual aids will be used with the children to support them to demonstrate their wish to 'stop' & 'go' (Wiles et al, 2005), as well as being used throughout the interviews to support children to express themselves and feel listened to (Winter, 2011). Should children wish to withdraw, permanently or temporarily, I would envisage that they would share their feelings with staff working and directly supporting them. Hence, staff should feel able to pass on the child's wishes. This will require careful thought to ensure that staff do not feel obliged to discourage the children from withdrawing if they so wished, with the misplaced intention of 'supporting their colleague's research'. Whilst any withdrawal may be frustrating for the researcher this cannot be allowed to impact upon the day to day therapeutic work undertaken by the MBS. The research methodology will be designed to take this into account and will allow for an appropriate dropout rate, of perhaps two children over the research period.

A clear expectation should be made when consent is requested that children and families engage with the research throughout the entire time period but pressure cannot be exerted to enforce this. If participants wish to withdraw it would be necessary to clarify whether they are withdrawing from any future involvement, or whether their existing involvement can still be utilised. Children will need to be re-assured that withdrawing will have no impact on their

placement within the MBS and it will be made clear that they do not have to give a reason for withdrawing. The participating children will be made aware, verbally and through the information leaflet, that they can ask questions and talk with staff from their treatment team (discussed later) about the research at any time.

Children should be made aware that what they share may need to be shared with other professionals if it is felt to be in support the 'welfare of the child' (Children Act, 1989). For example, children will be informed at the start that should they reveal something that may be harmful to themselves or others then I may be obliged to share this with a colleague, but I would do so in discussion with them. The children involved in the research will already be familiar with these issues from previous discussions undertaken at the MBS. However, children will be made aware that, except in extreme cases such as the need to ensure safeguarding, information will not be shared with their families or carers, and, again, this will be discussed with them. Whilst parents may request to know what their child has said to the researcher, any sharing of such information would compromise confidentiality, undermine the child's trust in the research process and the validity of the research would thereby become compromised (Parkinson, 2002). Furthermore, any breach of confidentiality would conflict with the principles set out by the BASW and BPS.

With regard to consent I am reminded of a film made of the MBS in 2003. One particular child gave their consent to be featured in the film, along with his birth mother and the Local Authority, and the film was recorded with him as an active participant. However shortly after the film was broadcast the child contacted the school to say that it was unfair that he'd been included in the film and he didn't wish it to be shown again. The school had no control over whether the film was shown again, raising questions about how to support a child who was distressed and who now wished to withdraw consent. He had watched the film and

experienced emotional pain from watching himself on the television. This is the pain that we aim to work with within the school, to make children aware of and allow them to develop coping strategies to deal with and understand such pain (Mulberry Bush, 2012). Throughout the research I must be clear, with all participants, of this remit, especially when seeking informed consent. Participants will be informed that they will be provided with a child-friendly version for comment before final publication of the thesis; but that once the thesis is published it cannot be withdrawn. Every effort will be made to fully anonymise cases to prevent children being identifiable, though the school will be named make this complex and requiring considerable attention. Each child will be made aware that they may be directly quoted in the final thesis and that details of their lives will be included, under a pseudonym. If there is evidence of additional trauma during the research then the research relating to that child will be halted immediately. Upholding my responsibility to the welfare of all readers (BASW, 2012; BPS, 2009), and before finalising the thesis, a child-friendly summary of the research will be shared with each child, who will still have the opportunity to withdraw from the research.

It is intended that at least some of the case studies will focus on the period directly after children leave the school. Whilst necessary to request permission for the research from the child's subsequent placement, whether this be a school, family or residential home, this should not impact upon the child's placement itself. Here, and throughout, the 'best interests of the child' must be the primary consideration (Children Act, 1989).

The families

Parental consent will be required where parents continue to have legal parental responsibility; alternatively consent will be required from the Local Authority with parental responsibility. This will be required prior to seeking consent from the child, in order to avoid a situation where a child gives consent but is then overruled by the person with parental

responsibility.

When asking parents for consent it will be important that they are made fully aware of the nature of the research and the benefits and difficulties that may arise, for the children and themselves. Parents will need to be aware that children may give emotive and distressing accounts of their early and family lives and will be encouraged to think about the support they may require around this issue.

Where children's parents do not reside together consent will be required from the parent with whom the child primarily resides. Where both parents do not share parental responsibility consent will only be sought from the parent with responsibility.

Mulberry Bush staff

It is not necessary to gain consent from each member of staff working alongside the children (likely to be in the region of 80-90 at some point during the research process). As previously discussed written permission will be requested from the Director and board of trustees of the school only.

Staff support may not be relied upon and an information leaflet explaining the purpose and process of the research, and issues relating to confidentiality of staff, will be made available to all staff. Acknowledgement will need to be made to the potential issues of staff reading the views of children. It is proposed that an arms-length advisory panel be established, as is IoE standard practice that can be utilised should such issues arise.³⁹ Decisions about potential impact on staff can then be made in consultation with the panel, should such a situation arise.

³⁹ Any advisory panel would need to include, or at least link directly, with the Director of the MBS for issues that relate to MBS staff.

Speaking with children and families about their backgrounds is a sensitive area; it has the potential to be supportive yet also to raise the sense of emotional vulnerability post-interview. Perhaps the issue is best thought of as 'who picks up the pieces'? In many ways this is part of the day-to-day work of the MBS, supporting children to be in touch with their backgrounds, yet ensuring they are not re-traumatised. Working with the issues is something staff are well versed in. The school culture is based on open and honest communication between staff members in order to best support the children and their families (Mulberry Bush, 2012). Part of the support for each child will be to ensure that all staff working alongside them are aware of the research process, when interviews occur, and are able to offer post-interview support, if required. Particular emphasis will be made to ensure the treatment team⁴⁰ are clearly briefed and that children are supported to use these staff should they wish to speak with someone about the research. As researcher consideration must be given to avoiding leading comments and questions, including unconsciously, any discussion must be undertaken in the role of researcher whilst avoiding the influence of being a practitioner – a hard, but essential, balance to strike!

Other professionals

Written consent will be required from other professionals within the children's professional network. Many of the children will be on full care orders which will necessitate overall consent to the research from a representative of the local authority, acting in loco parentis - normally their social worker or team manager from a Looked After Children's (LAC) team, but may extend to other professionals.⁴¹

⁴⁰ The treatment team model consists of the child's keyworker, teacher, therapist and family network practitioner.

⁴¹ Consideration has been given as to whether consent is required from the Association of Directors of Children Services (ADCS) research group. Given that the research will have passed through the IoE ethics committee, and is approved by the MBS, and that consent will be required from all participants I will not apply to ADCS for additional permission/approval. The structure of the ADCS is geared towards far bigger research proposals, where research is undertaken directly and seeks to involve local authority children's services departments

'Gatekeepers'

Research participants will be identified through set criteria, such as ensuring that placement dates fit within the research timeframe.⁴² Criteria will be designed to be fair and non-discriminatory (BASW, 2012) and aim to be representative of the MBS sample. However, using any criteria introduces the concept of the school as a 'gatekeeper' (Mason, 2004). This raises an ethical concern about the researcher exploiting the relationship between the school, as 'gatekeeper', and the children and their families (Flewitt, 2005). For example, parents may feel obliged to participate in the research in order to develop or maintain a good relationship with the school. Whilst a number of issues relating to 'gatekeepers' can be identified (Wiles, Heath, Crow, Charles, 2004), the most significant is the failure of the gatekeeper to provide opportunities for those involved to exercise choice; this is particularly seen in institutional settings, and especially in schools (Heath et al, 2004). To ameliorate this risk, formal and informal opportunities for participants to decline participation will be incorporated throughout the study (Mason, 2004) and as already discussed children made aware that any form of not participating in the research will have no impact on their placement within the MBS.

Confidentiality

Where children are considered competent to give consent they should be able to expect the same implied confidentiality that an adult might (Mason, 2004). In practice they should expect that what they reveal in their interviews is not shared with anyone else, except in anonymised reports.

(ADCS, 2010). Whilst individual social workers may be asked to give consent the research will not directly impact or involve local authority children's services departments.⁴¹

⁴² Consideration has been given to if a placement were to end prematurely. If near the start of data collection then that particular case may be dropped from the study. If sufficient data exists, and consent has not been withdrawn with the end of placement, the case study will continue.

Under the Freedom of Information Act (2000) children have the right to request to see any private notes, records or transcripts of interviews held about them, though not notes relating to a third party or that may be considered detrimental to the child's well-being. It is not unusual within the school for ex-pupils to contact the school asking to look through their files to see what professionals have recorded about them. Traditionally this has meant young people ploughing through vast quantities of documents which often replicate, and at times contradict, one another in order to try and build up a picture of their early life events. Some may find the research enlightening and helpful, but for some it may prove a difficult experience, bringing to light aspects of their past that perhaps they were unaware of. This should be acknowledged when consent is requested and the ongoing support of the Mulberry Bush offered at the time of the research and in the published thesis. Children will need to be made aware, verbally and through the information leaflet, of how long the researchers records will be kept for, it is anticipated this will be for a period of two years after publication.

Anonymity

Both BASW and BPS frameworks place emphasis on the respect and dignity of each participant. This will include anonymizing all participants. By giving a vivid portrayal of the child, their family and their backgrounds, those that know the child and the family are likely to be able to identify them. This will include members of staff, professionals, families and perhaps even in years to come the participating children or their MBS peers. It is highly likely that staff will be able to identify the children written about, though by the time of publication it is likely that these children will have left the school, and that any impact will be reduced due to being several years older and being in a different environment than when the research was undertaken.⁴³ It is not anticipated that staff being able to identify children will have a

⁴³ Consideration has been given to delaying the publication of the thesis in order to mitigate potential risk to participants. However, in discussion with the schools director, it is felt the risk is extremely minimal and the thesis should be published. The information leaflets will explain what is expected to be published, where and when.

detrimental impact on the child as the children will have left the MBS by the time of publication and are unlikely to be in contact with MBS staff.

Consideration has been given to the issue of whether children and families can refuse to be anonymous. It is not felt that this would be in the best interests of the child (Children Act, 1989) as, given the work, it is likely that this may meet some unconscious need of the participants. Some children and families unconsciously place themselves in the role of 'victim' and allowing people to clearly identify them may add to their sense of being a victim or add to their vulnerability. For some children there will be legal reasons why their anonymity must be maintained. I propose that in the consent forms it is made explicit that all children and families will be anonymized. If a child or family refuse anonymity then the implications will be discussed with them. If they persist it is proposed that they are not a suitable candidate to be part of the research. Although this may minimise the pool of children and families that can be drawn on it will support their emotional safety and development whilst maintaining the integrity of the research, as outlined in both supporting frameworks (BASW, 2012, BPS, 2009).

Where the placement of the child has been kept from the parent, for example for legal reasons, then in partnership with other professionals a risk assessment will need to be undertaken as to whether the case study jeopardises the safety of a children. If necessary then that particular case will not be suitable for inclusion in the study.

Role and influence of the researcher

As a researcher, employed within the organisation, I hold a number of roles: participant observer, manager, and researcher with relationships to children, to a lesser degree their families and to staff, all of which create complications in separating out research from

practice. Some practical steps will be taken to ameliorate the issue, such as wearing a distinctive 'researcher' badge during research contact times to denote the different relationship.

These roles have the potential to challenge my duty to support children to voice their true feelings (BASW, 2012). Supervisions with IoE tutors will be used to ensure this impact is minimised as much as possible and the issue addressed⁴⁴. To the staff involved I am a researcher, colleague and member of the senior management team. Whilst they may feel able to ask questions or challenge a researcher, my role as colleague and manager is likely to impact upon this. Similarly for the children, some will experience me as only as a researcher whilst others will experience me as a member of staff. It is possible that some will experience me as a member of staff who has had to maintain boundaries with them, possibly even physically holding or restraining them. Whilst I can keep some of these responsibilities to a minimum some may clash with my duty of care, since I cannot allow unsafe behaviour to occur no matter what the impact upon my research. For this reason responses from children and staff may be compromised. At the same time, my loyalty to the school may, unintentionally, compromise the research process. Supervision at the IoE will be invaluable to monitor my own analysis of the work and to ensure that the rigour of the research is maintained.

My role as researcher is further complicated in relation to representing what participants say - especially children. There is potential to 'speak in their place' and for the researcher's background and identity to shape what has been said (Alcoff, 1991). There is a need for the researchers own values to be put to one side, so as not to distort the research. It will be important to try to avoid re-shaping what participants have said through my own language

⁴⁴ It will also be beneficial to discuss these issues with the Mulberry Bush director in order to minimise the impact of my being a practitioner and enable me to operate in the role of researcher.

and interpretation (Fielding, 2004), though important to recognise this is never wholly possible, including what I include and exclude in the study (Bhavano, 1990) or through unconsciously referring to my own moral overtones that relate to participants (Humphries, 1994). As identified there is potential for a clash of loyalties between my roles which will need monitoring and challenging through self-reflection and use of supervision, or the already mentioned advisory panel. For example, there is potential for data to be represented in a manner that, consciously or unconsciously, reflects my view of the organisation at that moment in time. It is inevitable that selection and interpretation of data are influenced by the researcher values and roles to some degree but the need for critical distance and assessment remains essential.

It is often expected that ethical issues relate mainly to those participating in the research but, particularly given the ease of sharing information on the internet, there are inherent risks for the researcher too. If a child dislikes the picture portrayed they are free to voice this through social networking channels, blogs, and so on. They are not governed by the ethical considerations of the researcher.

Ownership of the data

A key strand of the research is using existing case material to build a clear and detailed picture of each child. Whilst much of the material will be written by staff within the MBS, some is written externally and the MBS does not necessarily own these case notes. This could have implications on how case note material is used. The legal framework requires that data provided to the school remain the property of the original author, and consent, from each author, would be required to use any such data (Data Protection Act, 1998). However, MBS has developed detailed background reports on each child as part of their placement. These reports will be used for the purpose of the study with permission being provided by the MBS directors and consent from children and parents (who will be discussed in the

records too). Parental consent will include their permission to use data accounts about them in the research.

In addition to highlighting the wide range of ethical issues I hope that this paper demonstrates my commitment, as a researcher, to considering the impact of my intended research on the children, their families, and the professionals involved.

Pilot phase

As part of the pilot study, the information sheets, consent forms and data collection instruments were used and subsequently reviewed. This highlighted several areas of wording which were unclear and demonstrated that the use of images on the consent form (see appendix 2) needed further development, due to the children's reading and comprehension ability. Data collected from staff and the child's family worked well and were as anticipated. However, the questions and methods used with the child required further refining, and the length of time for child interviews reduced to match the child's ability to focus. In addition, the pilot phase identified the need for a broader range of participatory methods (Punch, 2002a) to be available to the child and the need for much greater flexibility around the length of the interviews, which for children had been overestimated.

Main study

The research was undertaken in as transparent a manner as possible, drawing on my own 'reflexivity' and recognising my motivations for the study, as highlighted by Yardley (2000). While the research was intended to contribute to an understanding of therapeutic childcare, it was also hoped that more extensive benefits would accrue for community and policy-makers.

The pilot study had identified several learning points and areas which influenced the main study. Primarily these related to the research instruments, the type of interviews and the order of questions when working with parents. The pilot interviews were too structured, for some parents following a set order of questions was not helpful and interrupted their flow of discussion. Instead a more semi-structured approach to the interviews was required.

Further learning came from the transcribing and initial coding of the pilot interviews, which took significantly longer than planned and which proved inaccurate, leading to the research timescale being re-drafted to allow additional time. At this point, the proposed interviews were set into themes as shown in table 3.2 to ensure that evidence was collected covering the different area but ensuring that the overall collection process gathered the data required for the study.

	Theme 1	Theme 2	Theme 3
Child	History – when you arrived	Here and now	Looking ahead
Family	What happened before the MBS and now	What is happening now and looking to the future	
Staff members	Getting to know the child	Progress	
Senior managers/trustee	How do you understand the work of the school?		

Table 3.2: Interview themes

The main study was built around developing an understanding of the primary case through undertaking the literature review, archival data and documentary analysis, semi-structured interviews with senior managers and the development of the embedded units. Although in terms of data collection, a higher proportion of time was spent on the embedded units, this provided essential learning about the MBS as the primary case and formed part of the design for this purpose. The embedded units were mapped against (a) the time frame of each child’s placement at the school and (b) the research timeframe. This showed the methods of data collection as well as the frequency and duration of data collection interviews.

A schedule was developed allowing data collection and initial analysis to be undertaken simultaneously in an iterative manner. While the case study database, or case record (Patton, 2015), was established as a spreadsheet allowing data from all the sources of evidence, including personal reflections to be stored together. However, as the interviews were to be coded using software this, rather unhelpfully, led to two forms of data storage.

As previously mentioned, the issue of attrition was considered a particular risk to the study and one that quickly became apparent. Despite consent being given for the first child, shortly after the first child interview and a focus group with staff, overall consent was withdrawn. This led to one of the reserve cases being used as one of the main embedded units and the data collection process schedule being re-written. Despite initial feelings of frustration, this meant that an additional, though unplanned, pilot stage had been undertaken and a further review of the data collection instruments was undertaken. While all records relating to the withdrawn participant were destroyed.

Archival data and Document analysis

The literature review and ethnographic profile of the school, see chapters two and four respectively, had identified a partial history and development of the school but had not provided the depth of understanding required for the research question. A more comprehensive collection of texts and documents were gathered which incorporated all known publications about the school; documents from the school's website and annual reports; internal developmental documents and select notes from trustee meetings stretching back to the 1950s. These were analysed to develop a complete profile and understand the context of the case. The intention was that this context would then be further improved by the development of the embedded units.

The studying of each embedded unit commenced with a detailed analysis of written documents held by the school relating to that child, which included internal documents as well as externally written professional reports. Archival data documents were already collated by the school for each case and stored in a structured format but were consolidated by existing internal up to date reports⁴⁵. A profile was built of each child's known background and placement history in chronological order, ending with the most recent reports from the MBS. Part of this process involved joining internal MBS meetings about each child to hear and record how a multi-disciplinary staff team made sense of the child and to get a more in-depth feel for each embedded unit. During this stage, attention was paid not only to 'what' was said but 'how' staff spoke, for example, with warmth and tenderness or with frustration or perhaps ambivalence.

Inconsistencies and unanswered questions were highlighted and set to one side to see how these linked to the experiences gathered from other means of data collection, notably the interviews. Many of these inconsistencies related to gaps in knowledge of children's backgrounds, where previous professionals had often made their own interpretations, or judgements, as to the nature and cause of the child's emotional trauma. These inconsistencies were felt to be important data in their own right and would be returned to during the analysis stage.

In addition to noting the inconsistencies about the data relating to each of the children, I maintained brief notes about my responses, judgments and potential biases for each one. These were recorded to be able to put them to one side, to become objective and to recognise my own researcher bias. For example, many reports focused on medical rather

⁴⁵ Many of these internal reports were updated during the study period as part of the school's regular work. Each update was recorded on the case study database to ensure the most up to date information was being analysed.

than social diagnosis and internal documents were found to relate more to therapeutic models than medical ones.

Interviews

After gathering consent (see ethics section for further discussion), but before any interviews, I met with each participant to ensure they were clear about what was expected of them and what they could expect of me as a researcher. Information sheets for children, parents and staff were developed, and circulated to participants, along with a series of questions and topics to explore, linking identified themes from the literature review and the analysis of documentation with the research question. A verbatim introductory script, set list of topic headings and set closing comments were also developed, as proposed by Robson (2011), to ensure a degree of parity between not only the interviews but between the embedded units more generally, while also supporting validity. Each child based interview would again follow a set of questions and was built around a range of techniques to enable children's contributions.

Before each interview, the recorder and microphone were checked multiple times and attention given to ensuring each interview location was as quiet and undisturbed as possible. Each interview commenced with the information sheet; my reminding participants of my researcher role (shown visually through the wearing of a research badge) but recognising my role as a member of staff, and the potential implications of this for them and that content of the interviews would not be shared. Particular emphasis was placed on this last point to enable children to be clear that their parents and carers would not be aware of what was said⁴⁶.

⁴⁶ All participants were made aware that anything which I felt impacted the safety and well-being of an individual would need to be shared as part of safeguarding concerns.

For the child interviews, I met with the children on a 1:1 basis at a location within the school at a time, where possible, chosen by the child. Interviews commenced by reminding them of the purpose of the research and how they could use pictorial STOP / GO symbols to indicate when they wished to stop or start. All participants were also reminded that they were able to withdraw from the research at any point.

Interviews were semi-structured, though the structure of questions varied between interviews as children were more likely to ask their questions than follow those being asked, and it felt important to hear the child's dialogue. Where possible the interviews were participant-led and allowed to become a conversation rather than a series of questions, this was notably harder for the children being interviewed. A range of paper, pens, objects and photos of the school were available as a means to help reduce dependence on verbal questioning and response and introduce concepts such as free association. Children were engaged in developing a visual timeline of critical life-events and drawing and naming significant events, people and places. These were stored in containers decorated by the child and returned to for subsequent interviews as a reminder and non-threatening starting point to the interview. This worked well for two of the four children, one of whom brought their own participatory methods along in the form of puppets, but a more movement-based approach was required for the remaining two, one talking While going for a walk and the other While moving around room. Again, this was seen as important data and is considered later in the study. Supplementary interview questions were asked relating to emerging themes from the children's data, though without disclosing what children had shared.

Each child participated in three semi-structured interviews over sixteen months. This enabled the tracking of progress through the study, while helping ameliorate interviews where children might have been swayed by external events and feelings which were felt likely to inhibit or bias answers they gave. The length of each interview was dependent on

the level of engagement of the child, which could not be predicted until the interviews themselves took place, and generally lasted for no more than 30mins, though some were as short as 10minutes. Each interview concluded with the children saying, or indicating, that they had 'had enough' and notes were subsequently made to try later and identify if there were common points in the discussions where children wished to finish.

Although all four of the children acknowledged me around the school, in different ways, only two of them ever mentioned the interviews, or "that thing" as one referred to them. Children were always made aware when I had met with their parents or carers but reassured that nothing had been shared, to ensure they were not left anxious about possible meetings.

Alongside the interview, a record of significant interactions with children, and parents and carers was maintained throughout the data collection stage. This ensured a history of when children approached me for a discussion, whether about the research or not, or when I met the children in areas of the school, for example sitting next to one child in the dining area. Informal observations were of behaviours, discussions and interactions, all within the natural setting of the school.

Before parent and carer interviews, time was spent with them to answer their questions and to develop a necessary rapport with them. Central to the success of the parent or carer interviews was this rapport and them feeling they were participating in something relevant. Two interviews took place with each set of parents or carers over the sixteen-month data collection period. It had been planned that where parents did not reside together, they would be interviewed separately. However, this was not necessary as parents either lived together, or only one parent was involved.

Parents and carers were interviewed separately from children and given the option of undertaking the interview either in their home, at the school or, should they prefer, a more neutral venue. As such, semi-structured interviews with parents or carers were harder to schedule due to them being geographically dispersed. While this enabled them to be more at ease, for some interviews, it introduced environmental hazards, as discussed by Easton *et al.* (2000), with recorded noises of younger children playing and washing machines running being added to the recorded audio files. However, this limitation was considered to be outweighed by enabling the interviewee to have more control and choice.

As with the child interviews, each commenced with a reminder of the purpose of the study, their right to stop at any point or withdraw from the study completely, a clarification of my role as researcher, again the researcher badge, as well as a reminder about confidentiality. Having checked whether parents or carers had any questions before starting the overall themes of each interview were highlighted, and the interview questions commenced with interviews lasting for between 50 minutes and 80minutes. Each interview was recorded for subsequent transcription.

For the second interviews, a verbal summary from the first interview was provided to recognise that a period of between nine and twelve months had elapsed since the initial interview. This allowed parents and carers the opportunity to reflect on the themes of the first interview, what had happened before the MBS, and the transition into the MBS and related them to their current situation.

Focus groups

Staff focus groups were undertaken on-site, providing an advantage and disadvantage. While it was logistically more accessible to group staff during the working day, this meant that for two groups, there were interruptions from other parts of the school. More significantly

there was awareness that children, including some being discussed, were present on site which did not pose a direct difficulty but was undoubtedly a preoccupation for some members of the group. Staff were selected based on their involvement in each of the selected child cases and were drawn from the child's 'treatment team'.⁴⁷ This ensured those staff involved were familiar with the child, and their background, thus reducing ethical concerns about confidentiality. Each case involved two focus groups, mapped with the schedule of interviews for children and families.

Each interview commenced in a similar way to the parent interviews with the same reminders but with more emphasis placed on the issue of my role. Many of the staff involved had had long-standing working relationships with me for many years, so this issue was felt to be more prevalent. The primary difference experienced between the use of semi-structured interviews and the focus groups was the need to enable all members of the group to have a voice. At times this meant a thoughtful comment to individuals or the group to allow others to speak. Thus, the role I took became a mixture of the researcher, interviewer and facilitator. Each focus group lasted for between 45 and 75 minutes.

Towards the end of the data collection period, a series of semi-structured interviews with senior managers and trustees were undertaken, independently of one another, to provide a context of the primary case. Again, alongside the recorded interviews, notes were maintained, which included feelings and judgments from myself. These followed a set of questions directly related to the research question (Yin, 2014), see appendix 3 for interview instruments, and focused on how managers were able to describe the work of the school and the benefits, if any, they felt could be evidenced. These interviews all took place within

⁴⁷ Each child at the school has a treatment team who oversee their therapeutic provision. Each team consists of a minimum of the child's residential keyworker; someone from the child's class; a therapist and a family practitioner. As part of the research I joined the treatment team for the four children involved.

the school setting, and before each interview an information sheet was again shared and discussed along with an initial discussion about my role as a researcher. This was important to separate my role as a management colleague and place the focus of the interviews on the research.

However, the questions were used far more as a prompt to the discussion and to ensure the relevant areas were covered. The interviews had far more of a conversation feel to them, in part due to my working relationships but primarily in the use of question as more of a guide. These interviews lasted for between 1hr and 1hr 30mins and elicited a wide range of data for subsequent analysis. It should be noted that all three interviewees made an initial comment about "hoping they got the process right", an anxiety which is explored further in chapter 6. It was noted that these were the most straight forward interviews to arrange which again might have been a reflection on my insider-researcher role coming into play, though also linked to the commitment to research that each of the three senior managers independently referred to.

After all interviews, focus groups, and interactions with children, brief notes were made capturing my experience and added to the case study database. This process acted not only as additional data but as a means to de-brief myself of the information but also the experience and impact of the interviews. Staff were also made aware each time I met a child so that they could be mindful of any emotional impact that may arise for the child, though no issues were reported.

Appendix 11 Analysis and interpretation of findings: The example of group work

In this thesis the analytical framework adopted was phenomenological, complemented by a psychosocial framework. In this appendix I highlight how the two frameworks were used together to analyse and interpret the data, using an example based on group work. Extracts from the findings are included to highlight the process of analysing and interpreting.

Analytical frameworks

In this thesis, phenomenology has been understood as ‘trying to understand social and psychological phenomena from the perspectives of people involved’ (Welman and Kruger, 1999, p.189), or as relating to the lived experiences of people (Greene, 1997).

Complementing this, the psychosocial approach has been understood to draw on psychodynamic/psychoanalytic theories of the mind (Frosh and Baraitser, 2008), with strong links to a number of fields of practice, many of which relate to this study, including psychotherapy and group relations. The psychosocial approach enabled the research to take the position that our ‘inner’ and ‘outer’ worlds are inseparable, allowing for an analysis which linked what participants said with what was unconsciously being communicated. Combined, these theories present the perspective of the research participants, while taking into account the reflexive stance of the researcher (Froggett and Hollway, 2010).

The initial analysis was undertaken through a phenomenological frame using all the strands of data available to the researcher.

Strands of data

The following data chunks represent examples taken from each source concerning the example of group work.

Senior manager interview

Interviewer: How do you think staff understand the model?

Senior manager: The group work model runs through the school, and I think all the children will be in some form of group. Staff are trained in working in groups and are in many groups themselves....How? I think it's used at all different levels of the organisation. I think, throughout the staffing team, working in groups is very important....this can be hard and create anxiety for some.... Groups and levels in different ways. Examples from whole school study days, we have everybody in a room in a large group to the smaller groups that meet weekly and whether it's reflective groups or agenda meetings or whatever. (coded as 5e / 8)

Documentation

Group work group - A group which is set up and facilitated to address therapeutic needs via a focus on group processes and shared identity. There will likely be a relatively fixed sequence to sessions, a well defined physical space, some group rituals and the group will own itself and its processes as much as possible.

Boundaries will be clear and handover will be minimal. Groups will probably name themselves and they may not have an explicit task or focus beyond being in a group - if they do then being in a group will be an implicit aim. (Staines, 2017, p.2) (coded as 5e / 8)

Staff focus groups

Interviewer: how do you understand the group work model?

Staff member: most of the children prefer to be on their own, and that can be easier. It can feel that there are too many children to have them all together, in a family you wouldn't have seven children...it is quite a difficult thing to do, most of the children find it hard coming together even for mealtimes... (coded as 5d)

Families and children

Interviewer: how do you think your child responds to being in groups?

Parent: I don't think they are in a group, I mean they have meals with other kids but he doesn't really like being in a group so I don't think he is in any. (coded as 5b / 5e)

Interviewer: Can you tell me about some of the times you are in a group?

Leo: I'm not in any groups (coded as 5b / 5e)

Observational notes

1) Joined L's house after class...children started in rooms and house felt settled, brought together as a group to reflect/discuss the day. Children and staff all sat on cushions on the floor in a circle...I sat near the door...L, K and JV all removed themselves from the group...one staff went with them but allowed them to remain out...B started to swear and raise her voice, she looked uncomfortable being in the group...staff asked her to stop swearing before A (staff) commented "I wonder if it feels hard being in the group when other children have walked out?", this appeared to offer comfort to B who stopped swearing and fidgeting... (coded as 5d / 5e)

2) I sat outside the classrooms this morning, sitting with J & D (staff). The children all walked to their classroom with care staff....quickly children began walking out of classrooms...L was amongst them, shouting he didn't want to be in class with others kids - "I'm not stupid like M so shouldn't be with her..."...his teacher came out and explained that he was part of the class group and invited him in...L replied "I don't

want to be part of your stupid group...I always work on my own..."...the support staff reminded him of what the teacher had said but then J (staff) took him into Shifford and got him working on his own... (coded as 5d / 5b)

Reflective diary notes (kept as process notes after interactions)

Following observation 1 - ...although interesting to join L's house I was left with a strong feeling on unease. Sitting near L the sense of anxiety was clear, his body language irritable yet staff didn't pick up on this until he stormed out...Meeting with staff, later on, suggest this was normal. Other children also agitated but I'm left with a feeling that the staff are unclear why the group is happening, it felt uncontainable and unstructured... (code 5d)

Following observation 2 – surprised at the disconnect between teacher and J this morning...L projecting his anxiety, presumably about being in the group, but J allowing him to work on his own so avoiding the group. Is this normal? ... (code 5d)

Reflective analysis and interpretation of data

Hycner's (Hycner, 1999) distinctive five-step process of explicitation⁴⁸ was employed to investigate the constituents of the phenomenon while maintaining the context. This allowed me to remain close to the data, supporting a rigorous analysis (Morrow *et al.*, 2015). A pre-phase of 'familiarisation' (Colaizzi, 1978) was introduced to ensure I was familiar with the actual data, and not my perceived 'insider-researcher' perception of the data. This complemented the subsequent stage of 'bracketing' (Miller and Crabtree, 1992), which involved identifying my own perceptions and biases and aiming to set these to one side. Concerning group work, these were recorded and included 'beneficial to children and staff', 'all children in groups', 'central to therapeutic model' and 'staff well trained'.

Having set aside potential bias, all strands of raw data were coded using NVivo software. It was important not to create over-reliance on the software but to ensure participants' feeling

⁴⁸Bracketing and phenomenological reduction; delineating units of meaning; clustering the units of meaning to form themes; summarising each interview, validating it and, where necessary, modifying it; and extracting general and unique themes from all the interviews and generating a summary.

states were also captured and given sufficient consideration (Braun and Clarke, 2013). The delineating of the data into significant statements involved coding chunks of data multiple times before clustering them into emergent and principal themes, using what Colaizzi (1978) referred to as the researcher's 'artistic judgement'. The earlier examples of data highlight the final nodes (see appendix 6 for full list) attributed to form the significant statements and themes. Through using Hycner's (1999) method, seven themes were identified, of which the group-work model was one.

Although the phenomenological analysis captured the rich descriptions of the children and their settings (Bentz and Shapiro, 1998), it also highlighted several data areas which conflicted (see table 6). For example, senior manager interviews and documentation suggested a clear group-work model, yet family, child and staff interviews suggested the model was unclear or had not been explained to them, and observations suggested there was avoidance of attending and talking about groups. This potentially left three ways in which the data could be understood. To make sense of these contradictions, a psychosocial approach to analysis was drawn upon. This allowed for consideration of the transference and counter-transference, core psychodynamic concepts (Hollway and Jefferson, 2011), and drew on my reflective journal notes, bringing participants' anxiety levels and, for some, ambivalence into the analytic mix.

Psychosocially, my emotional responses gave a more in-depth understanding of what participants were communicating unconsciously, rather than purely relying on their verbal responses. Observations and reflections suggested children and staff found group spaces difficult and avoided them, but offered no interpretation of why. Reflective journal notes suggested uncontained anxiety projected onto staff and a high level of anxiety about children being in groups. These reflections match data from focus groups, senior managers and documentation. The issue of anxiety corresponds with the theoretical framework of

attachment and trauma, discussed in chapter two, whereby an emotional defence such as 'fight or flight' is implemented to avoid uncomfortable experiences. Thus, the psychosocial lens presented an alternative understanding of the group-work model as unclear. Viewed through this lens, it appeared the sense of 'not knowing' was not about poor training or a concept being poorly understood, but was a response to the intensity of the projected emotional defences against extreme levels of anxiety as a result of early-life trauma.

Principal theme	THE GROUP-WORK MODEL				
Phenomenological analysis	Model is unclear <u>Data: family/child/staff interviews</u>			Model is clear <u>Data: senior staff, documentation</u>	Avoidance <u>Data: observations, staff interviews, documentation</u>
Possible interpretation	Families are not told?	Documentation is not clear?	Poor training?	Documentation is not shared?	Children and staff avoid groups
Comments	Conflicts with, 'I probably was told.'	Conflicts with documentation data and some staff interviews	Conflicts with documentation data and some interviews		No conflict
Psychosocial analysis					Anxiety
Second interpretation on the balance of evidence	The sense of 'not knowing' was not about poor training or a concept not being understood, but was an emotional defence against extreme levels of anxiety as a result of early-life trauma.				

Table 6: Possible interpretations of group-work data.

Summary

Throughout the analysis and interpretative process, it has been beneficial to use both the phenomenological and psychosocial frameworks. The use of two complementary frameworks was beneficial in restricting my own bracketed biases (Groenewald, 2004), increasing the validity of the analysis and interpretation, while linking the subjective phenomenological viewpoint with the researcher's reflexive stance through a psychosocial lens. More significantly, the complementary frameworks allowed alternative interpretations of the original data to be explored, leading to a final interpretation that what was being verbally communicated needed to be explored at a deeper and more personal level, giving greater insight.