Understanding and responding to the emotional challenge of working in residential child care settings: the case for staff support groups

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Abstract

This paper considers why residential child care settings can be emotionally demanding for practitioners and examines how staff support groups can help practitioners to recognise and address these demands.The paper justifies the need for team members to regularly meet together with a trained and independent facilitator to reflect on their work-related perceptions, reactions and experiences. The paper concludes by offering some reflections on what it was like to be a participant in a staff support group and reflects on the relevance of such groups for residential child care practitioners working in the group care environment.

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"Many of us crumble, some more quickly than others. Others resort to de-fence mechanisms; a sort of survival whereby they "shut down", numb themselves so they don't "see" what's in front of them any more. But who watches out for this? Nobody. Nobody but us, and we're all so busy it's eve-ry man and woman for him or herself until it hits the fan."

(Dev, a social worker, quoted in The Observer, 17/1/10)

Residential Child Care Services and the Emotional Demands Placed on Practitioners

A residential child care service can be a tough environment to work in. Practition-ers are confronted by the expectations of others concerning their role, the nature of their working environment and by the level of distress facing children. Not surpris-ingly, these factors, taken together, can lead to residential child care practitioners experiencing increased demands on their own emotional resources.

Young people living in residential care are often there because they are unable to live at home or in foster care, and when we consider them as a group, their needs are likely to greater than other children. Meltzer et al. (2003), for example, sug-gest that about two-thirds of looked after children living in residential care centres in England have been diagnosed with some form of a mental health disorder; this compared with half of those living independently, and approximately two-fifths of those in foster care. Similarly, Ford et al. (2007) analysed the incidence of psycho-pathology in British children from different households, and found that "the preva-lence of psychiatric disorder was particularly high among those living in residential care and with many recent changes of placement".

While the intention of this paper is not to stigmatise or label a particular group of service users, at the same time, it is highly likely that many practitioners in resi-dential child care settings are spending a lot of their working lives empathising with young people who present with a range of challenging dispositions and behav-iours. Whitaker et al. (1998) indicate that a major factor in residential child care workers becoming stressed is the fact that they are working with adolescents pre-senting with complex problems and challenging behaviours.

Moreover, some commentators propose that practitioners should expect to be "in-vaded" by the emotional distress of young people. For example, Cooper (2006),

coming from a psychodynamic tradition, suggests that child care professionals "must be open to emotional disturbance arising from the work. To do this work well means being emotionally disturbed by it some of the time". But openness to this type of disturbance should, however, not be underestimated, particularly in residential child care services. For example, to protect themselves from the perceived threat of further psychological hurt, young people living in care may move quickly to act defensively. Often these acts can be expressed through upsetting or disturbing behaviours, to which the residential child care practitioner bears witness.

Furthermore, in comparison to other caring professions, "defences" such as the capacity to operate quasi-independently (e.g., control over one's diary and time) or the option of removing oneself from the workplace (e.g., offsite visits) may be less available to the practitioner based in a group care environment. Instead, child care practitioners frequently have to respond to unforeseen incidents that arise "on the hoof" (Ward, 2004) which involve complex emotional dimensions. Literally and psychologically, it is difficult for the residential child care practitioner to leave the room when the going gets tough.

Therefore, the working life of the practitioner in a children's residential centre is likely to be emotionally demanding. First, they work with service users who present with challenging behaviours and psychological states. Second, some therapeutic discourses expect practitioners to become "emotionally disturbed" by their work. Third, practitioners may have less room to manoeuvre "defensively" than other caring professionals. Faced with these challenges, can the wider academic and professional literature assist practitioners to make sense of the emotional work they do?

Perspectives on Emotional Work

Part of the challenge of residential child care work is to provide practitioners with a language to articulate how work affects them. And specifically, we can look to sociological, neuroscientific and psychological discourses to understand the possible effects of residential child care work on the emotional well-being of practitioners.

The sociology of emotions attempts to explain social actions by considering how people manage their emotional interactions with others. For example, Hochschild (1983) identified the concept of "emotional labour" to denote the "management of feeling to create a publicly observable facial and bodily display". Drawing from

Goffman (1959), she suggests that workers are influenced by the social representations placed upon them; for those working as social and health care professionals, this can result in them acting in ways which suppress or induce their feelings to convey a sense of safety or comfort to others.

However, the effects of emotional labour should not be underestimated. Gray (2009) suggests the term "emotional labour" brings attention to the similarities and contrasts between emotional and physical labour. James (1993) suggests that emotional and physical labour are both "hard, skilled work requiring experience, affected by immediate conditions, external controls… Emotional labour is an integral yet often unrecognised part of employment that involves contact with people" (p.96). And like other forms of labour, emotional work may result in challenges to the worker's well-being. Raines (2000), for example, suggests that the emotional dissonance between authentic and displayed emotions can have a negative effect for workers as they have to reconcile competing preferences.

Recent developments in neuroscience are beginning to suggest that we may have underestimated the effects of emotional work. For example, Swain's (2009) interview with Peter Totterdell, Director of the Institute for Work Psychology (IWP), University of Sheffield, points to recent research evidence which suggests it can become very tiring for people when they have to spend a lot of their time expressing inauthentic emotions or regulating how they feel. Totterdell's work forms part of the wider Emotion Regulation of Others and Self (EROS) research project, which is located across 5 UK universities. In defining "Emotion Regulation", the EROS (2010) website notes that "there is good evidence to suggest that emotion regulation relies on the same mental resources as other forms of self control (such as controlling a ball or resisting food). So doing one can deplete the resources used by the other. Like all forms of control, doing a lot of it can be exhausting. This is why doing a lot of emotion work (e.g., customer service) can be very tiring".

For those working in residential child care trying to understand their reactions to workplace encounters, the psychodynamic psychotherapy literature, which focuses on the nature of relational work from the therapist's perspective, may be another source of reference. While residential child care work and psychodynamic psychotherapy are different, practitioners in both arenas interact at an intensely relational level over time with those they serve. An important aim of psychodynamic psychotherapy is to help the client to develop a greater understanding of their psychic ailments; for this to happen the therapist needs to be able to reflect on their own reactions to the client. Therefore, the language of therapy is significant as words

are required to describe and understand what the therapist is experiencing during a therapeutic encounter. In turn, this may be a language which residential child care workers can use to characterise their own uncomfortable encounters with service users.

Searles (1959), for example, discussed how in the countertransference it can seem like the service user is attempting to drive the therapist crazy. Pope & Tabachnick (1993) suggests certain feelings such as anger, hate, fear, and sexual attraction or arousal, may emerge in the therapeutic relationship and can make therapists uncomfortable. Winnicott (1949) bravely titled an article, "Hate in the Countertransference" and suggested that therapist "must not deny hate that really exists". Doing otherwise, he suggests leads to therapy responding to the needs of the therapist rather than the patient. Haigh (2000) suggests that difficult interactions with service users in therapeutic environments can leave workers experiencing unpleasant feelings such as frustration, inadequacy or anger. Therefore, the rich tradition of psychodynamic psychotherapy writing which portrays the therapist's emotional world could be a rich vein for residential child care workers to draw on, in order to legitimise and depict their own responses to service users.

In addition, if the feelings of workers remain unexamined, the psychodynamic psychotherapy literature also indicates that there are likely to be negative consequences for staff and service users. For example, Reiser and Levenson (1984), explore how diagnosing an individual as suffering from borderline personality disorder may in some instances fail to reflect accurately or even approximately the clinical status of the patient but instead serve to "express countertransference hate" (p. 1528). Moreover, Main (1957) indicates that the "sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behaviours disguised as treatment" (p.129). For group care settings, Menzies-Lyth's (1959) frequently cited case study provides a graphic example of how caring professionals can respond if the emotional effects of work are not sufficiently explored. In an examination of why the training system for nurses was under strain in a particular UK general teaching hospital, she noted that the hospital organised the working day in a way to protect nurses and trainees from experiencing feelings such as anxiety, anger, love and hatred, which often arose from their interactions with patients. However, the organisation of nursing defences had consequences. For example, Menzies-Lyth (1959) noted instances of nurses depersonalising the patient (e.g. "the liver in bed 10"); a closed culture which did not support or encourage nurses to demonstrate feelings of anxiety or strain; and a reluctance by nurses to accept responsibility in decision-making without seeking permission from more senior staff.

However, organisations might not be the only instigators of defence mechanisms: workers may also play an active part. Morante (2005) writing about the distress felt by nurses working in an eating disorders unit, suggests that they may unconsciously protect themselves from witnessing emotional pain by becoming superficial, dogmatic or rigid in their dealings with patients. While these types of defences help nurses to avoid consciously considering anxiety, they do little to transform its presence.

Good professional practice is underpinned by a range of managerial, procedural and resource supports (Kapur & Wilson, 2010), but these will remain insufficient if we do not find the words to describe and respond to the impact on the residential child care practitioner's psyche. Being familiar with the discourses around emotional self-regulation and countertransference is likely to be beneficial to those working in residential child care settings. However, as Dennehy (2006) notes, this is not always easy to achieve because there can be a reluctance to use certain words (e.g. hate) to convey the nature of the reaction to the service user.

Therefore, in addition to learning a legitimate academic or professional language to understand and convey their reactions to service users, the rich diversity of residential child care workers accounts must also be given permission to be heard. As Plummer (1995) suggests, in situations where only certain accounts can be told, the nature of story-telling itself requires exploration. Nonetheless, even if individual supervision sessions could be used as an opportunity for the residential child care practitioner to honestly talk about the impact of work, such an individualised form of exploration, reflection and support around the emotional challenges of work may be insufficient to respond to the needs of workers in the group care environment. The next section examines why this may be the case.

Is there a need for Staff Support Groups in Residential Child Care Services?

Individual supervision is likely to be beneficial if it provides a safe space for the residential child care practitioner to reflect upon how work affects them. Good supervision can contain and make more manageable the anxiety and pain of the practitioner, as it facilitates the practitioner to reflect on their own emotional reactions and to learn from their experiences (Bion, 1962). However, for those working in group care settings, individual supervision may not be enough. More support

may be needed in settings such as children's residential centres, not least because some service users can have a powerful effect on the functioning of teams. Again we can examine a case study from outside of residential child care to consider what some of these effects might be.

The "Special Patient"

Tom Main (1957), a psychiatrist, worked at the Cassel (Adult Psychiatric) Hospital in London, and he formed a group with nurses to review the cases of 12 patients who were considered to be "major nursing failures". The use of a group was considered to be important to explore issues because

> *"…only a group could achieve the capacity to recall past events with the merciless honesty for detail and corrections of evasions and distortions that this one required from and tolerated in its members."*

(Main, 1957, p.132)

Main (1957) suggests that some patients are able to distress those who look after them, and the presence of what he calls the "Special Patient" was evident from the group's discussions. Despite their poor prognosis, Main found that some patients were able to elicit a huge effort on the part of some staff. Because of their initial appeal and neediness, staff engaged in close relationships with these patients; these bonds were later reinforced by their shared participation in crises. Some nurses came to believe that they possessed qualities that other staff lacked; for example, they were able to understand the patient and their moods better than other staff members. Main's group named these features: the "Sentimental Appeal" (from the patient), and the "Arousal of Omnipotence" (in the nurse).

However, over time these patients slowly became unappeasable; attempts to help them increasingly failed, even with staff working harder to placate them. The patients' need for attention was considerable. Workers also felt "pressurised" by patients to demonstrate their interest in such a way as to show that they enjoyed doing so! Despite these pressures, nurses talked about not being able to do enough for these patients. Main suggests that such patients "induce not only sympathetic concern" (p.140), but also a sense of responsibility in the worker. Broadly speaking, the presence of these patients in the institution resulted in the creation of in-groups and out-groups among staff. Within this inner circle the patient would be-

stow confidences in such a way that each staff person thought she alone enjoyed a privileged intimacy. However, in Main's group it was revealed that other workers also knew such confidences and felt that they too held a special relationship.

The out-group was not principally involved in the treatment of the patients, and they held mixed emotions about the in-group's relationships with the patients. Initially, some felt resentful and jealous. Later on, the out-group felt that the in-group was too enmeshed with these patients and unrealistic about treatment. In contrast, the in-group felt that the out-group was insensitive, suppressive and unsympathetic. Main (1957) suggests that over time some of the in-group nurses became too disturbed to carry on working through a combination of losing the support of their colleagues and because their own anxiety and despair about the patients' future was insufficiently contained. This disturbance could manifest itself in nurses becoming sick or suggesting that the patient required a different type of care. These types of case failures, Main (1957) suggests, can leave a worker feeling sadness and anger towards others and themselves.

While good supervision assists the practitioner to reflect on how work affects them, the nature of a children's residential centre may trigger psychic responses within a team that cannot be adequately handled in a one-to-one supervision meeting. Just as any residential child care practitioner experiences from their perspective the mini eco-system that is the workplace, other practitioners also construct their unique perspectives. Recognising these different perspectives and the ensuing tension which can arise in a team requires a wider lens than individual supervision is able to provide. Waddell (1989) makes a distinction between practitioners undertaking servicing and serving functions in their work. These concepts can be borrowed to think about the different ways in which workers can be supported to explore what is happening at an intrapsychic level within the team. Servicing focuses on being busy, undertaking practical tasks and doing things. Serving involves awkward silences, often going to a place of pain and discomfit, usually without finding solutions, and yet perhaps making the emotional pain of work more bearable.

Team meetings are not normally the place for the "serving" kind of reflection, as the business of running the unit can be used as an evasive strategy. Main (1957) suggests convening regular group discussions – which I call staff support groups - can allow staff to acknowledge painful emotions and "staff ailments" that arise in work. By "staff ailments" Main (1957) means our unique capacity to blame and condemn others for "their limitations of theory, ability, humanity or realism" (p.141), and also our unwillingness to take responsibility for our own beliefs and actions particularly

in circumstances where the work with service users is not progressing well. However, staff support groups need to be handled carefully. Haigh (2000) suggests that if this type of group – which he calls a staff sensitivity group2 - is used inappropriately or developed without clarity of purpose, it can lead to, for example, team conflict by exposing anxiety. To safeguard against this happening, he believes that a number of issues need to be addressed in order for a group space to be established where the mental pain arising from work is given a safe space to be recognised and acknowledged. Issues to address include membership criteria; timing & location; facilitation; and the non-participation of staff. The next section gives an account of what it felt like to be a member of a staff support group.

What is it like to be a Member of a Staff Support Group?

I worked as a social worker on a multidisciplinary team at an Adolescent Eating Disorders Service, in the south of England, between April 05 and September 06. The Eating Disorders Service provided a specialist 10-bed inpatient unit for young people (12-19 years) who have been diagnosed with an eating disorder (predominantly anorexia nervosa).The work at the Eating Disorders Service was often stressful. Young people arrived on the unit at a very low weight. Observing young people's concentration-camp like appearance, and responding to their behaviours and mental states were day-to-day work realities (e.g., excessive mood swings, fears of becoming "fat"; self-harm; surreptitious exercising, and disingenuous methods of smearing food).

Interactions between staff and young people around food often involved some form of conflict. Nurses spent hours every day trying to coax and persuade young people to eat, many times unsuccessfully. There was the risk that one meal time could run into the next. Not surprisingly, the intense nature of the work triggered a range of feelings and attitudes in staff including: fear about a young person's condition; anger that they were not eating; frustration towards parents deemed to be insufficiently supportive or assertive; and anxieties about case management (e.g., nasogastric intubation).

Menzies-Lyth (1959) described nurses using a depersonalising statement such as "liver in bed 10" as a strategy to reduce feelings of anxiety. Correspondingly, to

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2   The staff support group I describe in this paper shares many of the characteristics of what Haigh (2000), and Winship & Hardy (1999) classify as a staff sensitivity group. I use the name "staff support group" because this was the name for the group I attended.

distance ourselves from uncomfortable feelings associated with the invasive act of applying a naso-gastric tube, staff used to say, "she will need to be tubed". As Morante (2005) notes, staff are "invited either to watch the anorexic wither away or to sadistically force her into existence." Possibly one of the most stressful events at the Eating Disorders Service is when a discharged patient returns to the unit at a lower weight than when they were first admitted. I found such occasions to be disheartening. In such circumstances, Willner (2002) suggests that it can feel like an annihilating experience for workers: the anorexia disease is strong and the worker is having little effect. The Eating Disorders Service helped staff to acknowledge and tolerate such mental pain by providing a weekly staff support group meeting.

"The Support Group"

The Staff Support Group (colloquially known at "The Support Group") met every Tuesday afternoon, between 2.00pm-3.00pm. The group's membership consisted of all the clinical staff who worked with service users and their families. The members included nurses, nursing assistants, the consultant psychiatrist, team medical doctors, psychologists, the occupational therapist, the family therapist and the social worker. The support group was facilitated by a psychodynamically qualified and experienced group analyst who had a nursing background. The facilitator did not work in the Eating Disorders Service and had no other clinical contact with the staff team. The meeting took place in the same room every week. When we entered the room at 2.00pm, the facilitator had arranged the chairs in a circle and was already sitting down. People came into the room, usually in dribs and drabs.

I usually felt that I was leaving the Ward behind when I entered the room. However, the mood at the start of the meeting was never the same. Sometimes there was a playful and resistant mood among staff. At other times the atmosphere was more reflective and expectant. Often the presence of a recent encounter with a young person was almost tangible. Entering such a meeting space *is* difficult for staff. Often it was not easy to get staff to attend on time either because they were dealing with a "crisis" involving a young person or because a staff handover meeting was running late. While these may have been "excuses", at the same time it is hard not to be unsympathetic with Waddell's (1989) distinction between "servicing" and "serving" the service user and thinking about how this distinction plays out in the commitment of staff to attend a support group. Unsurprisingly, staff may want to defend against touching the emotional pain of work.

What would happen during the hour? There was no agenda and the facilitator rarely commenced proceedings. Issues ostensibly reflected on by the group members included the arrival and departure of young people from the unit, and the rewards and difficulties of working with certain service users and their families, and other agencies. Although the facilitator did not ask too many questions or make too many reflections, I felt one significant role he played was to consistently, and sometimes very directly, remind us of our work with very sick young people. By conducting the group in this way, staff members had permission to talk about recent episodes and encounters they had with services users and their families. Often these were sad stories, where people became disappointed. For example, the expectations around a weekend's leave for a child returning to their family had not been realised. While these stories were also shared at ward round meetings, the purpose of their telling at the staff support meeting was not to inform the next steps of treatment, instead it was to safely touch and contain our ongoing toil.

Although it was somewhat easier for staff to discuss their feelings about individual patients and their families, the facilitator sometimes brought our attention to acknowledging any tensions likely to be present in the team. For example, I remember at one meeting where staff members were discussing conflict in the patient group, the group facilitator interjected and said, "I wonder what the patient group is acting out that is not being discussed in the staff group?" And while group members might not have said anything in response to such an interjection, it left us all with a question to think about. While staff members were given the space through their work-related stories to acknowledge feelings of despair, frustration and hopelessness, the mood could shift in the room, and sometimes was lightened by a funny story – perhaps another form of defence - about something that happened on the unit. The group always finished at 3.00pm, even if attendees were in full flow discussing an issue. The function of the group was not to provide practical solutions. Instead there was something cathartic about having a regular, safe and independently-facilitated space where the emotional burden of work could be recognised and explored. In other words, an environment was created for "engaging with and tolerating psychic pain as a means of transforming it into something more bearable" (Fox, 2005, p.181). I can identify two particular benefits from regularly attending the staff support group meetings.

Coming to Terms with "The Special Patient"

Staff support groups may be a resource for teams to reflect on their work with longer-term service users. For example, the nature of the anorexia disease often results in eating disorder units having contact with certain young people and their families for long periods of time. As a result, quite powerful attachments can be formed between staff, patients and their families. However, not every member of staff is as intimately involved in each case, and therefore, it was amazing to witness the sometimes quite different reactions in a highly-qualified and experienced professional team towards a particular service user and their family. Although ward round and review meetings allowed staff to consider the welfare of the young people, the staff support group meeting provided us with a safe space to reflect on our responses to working with service users and their families. While we may not always be able to correct our "evasions and distortions" (Main, 1957), a safe group space may give us the opportunity to reflect on how our personal reactions get tangled up with our "professional" views about what we believe to be the best course of action for the service user.

Greater Awareness of the Humanity of other Team Members and the Strain of their Jobs

For many people, the experience of finding that others can suffer anxiety, uncertainty or other problems can be reassuring. Sometimes a person has a sense of being very isolated in his life, imagining that others manage their personal difficulties easily, and that he is to blame for having problems.

(Hughes & Riordan, 2006, p.110)

Sometimes I did not want to attend the support group meetings for different reasons, including tiredness, a preference to complete other "tasks", and a reluctance to get in touch with my own emotional pain and witness the painful stories of others. However, attending the support group reminded me of the humanity beneath our professional roles. It enabled us as a team to reflect on how the personalities and behaviours of young people – individually and as a group – impacted on us, as individuals and as a team. I developed a greater appreciation of the role and responsibilities of others. I came to understand how difficult it was for human beings – not nurses - to feed patients. The effect of the many demands - from managers, families, referrers and accountants - placed on the consultant psychiatrist became transparent. Her humanity

rather than her role became more visible, resulting in, I believe, an increased sense of empathy towards her from the rest of the team. Hopefully, other staff better appreciated the difficulties of social worker, particularly the challenges of engaging with families and local authorities!

Conclusion

Main's (1957) "Special Patient" could today be characterised as having a borderline personality disorder. An object relations explanation for such a disorder might suggest that the service user is unable to tolerate the co-existence of loving and hateful feelings, and ultimately projects these feelings into different parts of the team. Consequently, according to McWilliams (1994), some staff members will be sympathetic toward the service user and want to help, and other members will be antipathetic. While many clinicians believe it is wrong to diagnose borderline personality disorders in young people less than 18 years old, at the same time it would be surprising if some young people in children's residential centres did not behave in ways (e.g. conduct disorders) which provoked different reactions within a team. At the same time, the insights offered by Main (1957) would suggest that individual supervision is not a sufficient supportive resource for residential child care practitioners where a range of reactions to service users is evident among team members, which can lead to team splits occurring.

Although McCann James et al. (2009) correctly note the need for psychodynamic concepts such as transference and countertransference to be treated cautiously, tensions which arise as a result of staff holding different perspectives about service users may be moderated by creating a safe space for practitioners to reflect on how work is affecting them. However, participation in such a staff support group is not the same as workers providing one another with informal support. Staff support groups allow an organisation to acknowledge that highly-charged care work drains its practitioners. Such groups are necessary because what happens to the psychic pain of residential child care work if it is not considered?

Yalom (1995) defined therapeutic factors in groups as the "the actual mechanisms of effecting change in the patient". I would suggest that a number these factors may be present in staff support groups:

- Universality – others share problems similar to me; I'm not alone
- Catharsis – emotional tension is released

- Interpersonal learning - finding out about oneself & others
- Development of socialising techniques - learning new ways to talk about feelings, observations and concerns

Staff support groups are not a therapy group for staff; the focus is not on the worker's life story: the focus is on the effects of emotional work. While staff support groups may be a vehicle for workers to collectively contain and transform the psychic pain of work, for some workers the coming together of autobiography and work may require additional exploration, perhaps through individual therapy.

While work can be rewarding for the residential child care practitioner, it is also likely to be challenging. To perform their duties well, residential child care practitioners need to be adequately supported in order to tolerate the pain and discomfit facing them, often on a daily basis. So how can practitioners remain emotionally resilient in light of the difficult experiences they encounter in the workplace? First, we need to sufficiently acknowledge the challenges of the working environment. Practitioners may have less flexibility than other caring professionals to remove themselves from draining encounters with demanding service users. Moreover, some commentators such as Cooper (2006), expect practitioners to become "emotionally disturbed" by their interactions. Second, residential child care practitioners can benefit from developing a language to articulate the effects of work. Adopting the language of psychodynamic psychotherapy and using neuroscientific research evidence, allow practitioners to say that interactions with service users can be unpleasant and tiring. Third, if we do not sufficiently acknowledge the emotional burden placed on those who work in residential child care – and particularly those who work in group care environments – we should not be surprised by negative consequences (e.g. depersonalisation, team splits).

Regular supervision meetings are of course essential for all residential child care workers, and good practice promotes a dual-focus approach: operational and self-development (O'Neill, (2009)). However, for practitioners working in group care environments such as children's residential centres, individual supervision may not be enough. If the range of feelings and perceptions which inform the responses of *different* workers towards service users are not explored at a wider forum, it is likely that a team's functioning and cohesiveness will become undermined. Team members may also benefit from reflecting together on the difficulties of their task. For such explorations and reflections to take place in a residential child care team, the establishment of a staff support group may have some merit.

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