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Observation as a therapeutic intervention for infants and young children in care

Jenifer Wakelyn*

More than half of all children entering care in the UK are infants and children under five. The emotional and mental health needs of this population tend to be overlooked. Research described in this paper aimed to find out about the experience of an infant or young child in care and to inform training and support for health and social care professionals. The study found that therapeutic observation with a looked-after infant was feasible and provided an in-depth perspective on the experiences of the baby and his foster carers. The paper outlines the clinical context, defines therapeutic observation, describes stages in the first year of life of the observed infant and his transition to adoption, discusses functions of the therapeutic observer, describes applications of the research and makes suggestions for further research.

Keywords: infant in care; looked-after child; foster care; transition; therapeutic observation

Introduction

In this paper I describe a research project exploring the use of therapeutic observation with an infant in foster care. I then give a brief account of some applications of therapeutic observation in a specialist mental health service for children in care.

The clinical context

Around 12,000 children under the age of six enter state care in the UK each year (DCSF, 2008). Their physical and psychosocial adversities include low birth weight and small stature (a majority are under the third percentile for weight and head size), poverty, poor parenting, severe mental illness in family members, maltreatment, severe family dysfunction and neglectful and chaotic households (Hill & Thompson, 2003; O'Connor, 2003; Sempik, Ward, & Darker, 2006). These factors precipitating entry into care may be compounded by multiple changes of caregiver both before and after entering care the care system (Clyman,

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Harden, & Little, 2002; Reams, 1999; Ward, Munro, & Dearden, 2006). The outcomes for young people leaving care are bleak: 75% of young people in care leave school with no qualifications; 17% of female care leavers become pregnant as teenagers; one in five care-leavers become homeless within two years of leaving care (Haywood & James, 2008; McAuley & Young, 2006). Victims of child maltreatment are rarely able to form secure attachments, and are subject to enduring physical, psychosomatic and mental health difficulties in adult life (Werner & Smith, 1992).

The effects of maltreatment and of severed relationships with caregivers on infants and young children are complex, pervasive and longstanding. Powerful emotions, and defences against these emotions, escalate in professionals whose work brings them close to unparented infants and young children. In the absence of a mediating 'family envelope', the impact of these dynamics is particularly powerful for those responsible for the youngest children in care. This context, exacerbated by the ongoing reverberations of family breakdown and adversarial legal processes, militates against the emotionally attuned, 'mind-minded' care that infants and young children most need in order to be able to begin to recover from trauma and deprivation.

Infant mental health research has had a chequered history. The findings of pioneering infant mental health researchers and practitioners, such as Fraiberg and Fraiberg's studies of pathological defences in infancy (1982), have proved peculiarly resistant to dissemination. Cultural differences, language barriers and resource constraints are just some of many obstacles to awareness of the impact of the formative experiences of the youngest children in care. However, an important step has been taken in the first NICE guidelines on promoting the health of looked-after children, which highlight the significance of children's attachments to their foster carers, and recommend training in infant mental health for social care professionals (NICE, 2010).

Vulnerability to mental health difficulties

Much research on the prevalence of mental health difficulty of maltreated young children and those in the care system has been carried out in the United States. For example, in a mental health screening of abused and neglected children entering care in the United States, Urquiza, Wirtz, Peterson, and Singer (1994) found that 39% of children under four scored in the clinical range for internalising difficulties, while 27% had developmental difficulties. In a study of children under the age of four in Oregon, 61% of children were diagnosed with a mental health disorder; a third of children had clinically significant levels of internalising problems, while a quarter had externalising difficulties (Reams, 1999).

A recent screening of looked-after children under the age of six in an inner London borough found that almost 70% of children met criteria for at least one diagnosis of mental health and developmental disorder. Over 40% of children had two or more co-morbid conditions (Hillen, Gafson, Conlon, & Rosen,

2012). Most developmental difficulties had been identified in statutory health assessments, while mental health difficulties tended to go unrecognised. The authors comment that the level of distress in these children was significant in itself, while also of significant concern because of the correlation between early adversity and long-term prognosis.

As these pervasive difficulties become entrenched with age, they become more difficult to treat (De Jong, 2010; Lanyado, 2003; Van der Kolk, 2005). In the US, trials have been carried out of interventions to support children through their foster carers (Dozier et al., 2009), but evidence-based and accessible mental health interventions for this group of children have yet to be developed in the UK.

Access to services

It is relatively rare for children under five to be referred to mental health services. Mental health intervention is more often sought at an age when the combination of emotional, behavioural and social difficulties leads to risks of school exclusion and foster or adoptive placement breakdown. Paradoxically, 'the developmental plasticity of babies and toddlers is used ... to justify the absence of timely interventions' (Lieberman, 2002). Children's difficulties may be minimised, often overshadowed by legal or inter-professional conflicts that may replicate the family breakdown precipitating their entry into care (Britton, 1983). Additional factors aggravating failures in mental health provision for children with high levels of need include placement mobility, fears of stigma or blame that might ensue if the needs were recognised, lack of confidence that services could help, and shortage of specialist staff and resources (Haywood & James, 2008; Hillen et al., 2012).

Foster care

Half of all children who enter the care system remain looked-after for between one and five years, while over one in five children remain looked-after for over five years (DCSF, 2008). Foster care is the placement of choice for the vast majority of looked after children in the UK, and has been described as the 'fundamental bedrock' on which services for looked-after children in the UK are built (Wheal, 1999). However, policy initiatives and practice guidance tend to marginalise long-term foster care, focussing rather on short-term or 'task-centred' foster care as the paradigm. Foster care has been described as 'under-theorised' (Berridge, 1997) and 'effaced' from policy discourse (Craven & Lee, 2006). Sinclair, Gibbs, and Wilson (2004) observe that 'interventions recognizing the unique experience of foster children and foster family dynamics were found to be lacking in the current literature'.

The marginalisation of long-term foster care is linked to difficulties in conceptualising the needs of children for whom family reunification is not viable

or who may experience multiple re-admissions to care. In 'The lives of foster carers: Private sacrifices, public restrictions', Nutt (2006) highlights the precarious balancing of private and public tasks negotiated by foster carers 'at the interface of several conceptual worlds', with the result that 'their status is ambiguous, their task full of paradoxes and their lifestyle conflicted'. Having been renamed 'foster carers' as opposed to 'foster parents' (in the UK), many feel that they function in a kind of limbo, with neither personal nor professional identity or authority. I argue in my study that clearer conceptualisation of the complex emotional and psychological tasks of foster carers is needed to meet the emotional and development needs of looked-after children and to inform multi-agency professional practice.

Therapeutic observation

In therapeutic observation, the techniques of once-weekly psychoanalytic infant observation are employed to provide a particular type of mindful attention in a context where there is a clinical need. A therapeutic observation differs from a training observation: the clinician is a trained observer, grounded in the detailed study of the vicissitudes of family life and relationships where, for the most part, difficulties are within the ordinary range of 'good enough parenting'. The method has been used most extensively with premature infants (Lazar & Ermann, 1998; McFadyen, 1994; Negri, 1994) and children with signs of infantile autism, (Gretton, 2006; Houzel, 1999, 2010; Lechevalier, Fellouse, & Bonnesoeur 2000; Rhode, 2007).

Infant observation as a therapeutic tool is reviewed in a special issue of 'Infant Observation' (1998). Berta and Torchia (1998) identify benefits accruing from the therapeutic observation of a baby who had been refusing food and failing to thrive. The detailed observation of the baby 'in all her states', the delineation of a context centred on the baby, different from the rest of the family, but at the same time immersed in it, and the presence of the observer as a third party, outside but involved with the family in witnessing the baby's growth, are seen as creating a space for parents to reflect on the baby and on themselves as parents, leading to significant improvements in physical and psychological well-being. Houzel (1999) describes therapeutic observation as a minimally intrusive approach, based on home visits and thus capable of reaching families who are cannot access clinics, and compatible with the full range of multi-disciplinary interventions. The model permits a rapid response to clinical need and is highly cost-effective compared to outpatient treatment.

Therapeutic observation has also been applied with children at psychosocial risk. An account of observational work with a young child who was moved in and out of foster care during her first two years is provided in a collection of essays on young child observations in social work training edited by Bridge and Miles (1996). In a study of five vulnerable infants observed once-weekly in their homes from birth to two years, Briggs (1997) suggests that the observer's

attention can facilitate parents' capacities to make links and to see and respond to their child. Tarsoly (1998) describes observations of a number of children in a residential nursery in Hungary which enabled her to support their carers to deepen their own capacities for observation and form more meaningful relationships with the children. Hall (2009) has developed a model of therapeutic mother-infant observation during care proceedings. One of the benefits of this approach is the regularity of contact it provides, which social workers cannot offer to their clients because of their volume of work. The observations were found helpful by mothers and the social services networks. With appropriate monitoring and supervision in place, the babies she observed were able to remain with their mothers.

Rhode (2007) outlines some of the functions of a therapeutic observer, who may help parents and children to connect, perhaps by voicing wishes or feelings of child or parent that might otherwise go overlooked. The observer can embody a regulatory, third-party position by recognising interactions that she is not directly involved in; modulating separations, by registering the child's response, or by referring verbally to the absent mother or carer, is particularly important. The observer also carries the function of experiencing aloneness and rejection, being able to be left out or left behind, and to hold on to and mentally digest these experiences.

Rhode highlights a primary function of observation as witnessing: 'While this may seem quite a modest function, it has profound implications on an existential level' (2007): being seen and seeing oneself reflected, is a foundation of the sense of self. Rhode also discusses the observational function of identifying in turn with different members of the family. In the study I describe here, the potential identifications included those with social workers and professionals in the care system. Paternal and maternal parental functions are also reflected in a therapeutic observation. The provision of a reliable structure, in the regularity of the weekly visit and the consistency of the observational role, exemplifies paternal function, while receptivity and attention exemplify maternal functions. Combining these functions allows the observational role to encompass maternal and paternal aspects of the 'family envelope'.

Houzel (1999, 2010) discusses different aspects of receptivity in therapeutic observation: perceptual receptivity includes the capacity to pay attention to details and sequences of behaviour, sounds, gestures and movements; emotional receptivity is provided by the observer towards the baby and family members, and helps parents to realise the value of the attention that they can give to their child. For Houzel, unconscious receptivity is the most powerful of the observational functions and the most distinctive aspect of this intervention. Unconscious receptivity allows the observer to receive communications at the deepest level. These communications are processed in the seminar group or supervision that is an essential element of the intervention. Contained by the discipline of the practice, by the seminar group and leader, the observer is helped to carry a containing function for the family.

The observational research project

As a child and adolescent psychotherapist working in a specialist mental health service for looked-after children, I drew on my observational training in work with patients whose primary attachments have been severed, and with their foster carers and professional networks. I wanted to explore the further potential of observational approaches to provide a deeper understanding of children's early experiences and of the challenges faced by foster carers in responding to their needs.

The idea that gathering a closer acquaintance with the experience of a baby in a temporary placement, and with the foster carer's 'balancing act' in this process, could enhance care planning and the understanding of transitions for children of all ages, met with a positive response from social services commissioners. The project was a single case study which aimed to find out in detail about the experience of an infant or young child in care, to address the under-detection of mental health and emotional difficulties, and to inform professional training. Ethical approval was granted by the local research ethics committee. Consent for participation in the study was obtained from the head of the social work department and the child's social worker and foster parents. The research tested the feasibility of using therapeutic observation with an infant in foster care, explored the learning gained through this process and discussed themes identified in the data analysis.

The baby I am calling 'Rahan' was cared for by 'Nadira' (all names and identifying details have been changed for confidentiality) and her family from the day of his birth. Nadira and her husband were first-time local authority foster carers with three older children of their own.

The once-weekly observations began when Rahan was three months old and lasted for 10 months until he was adopted at the age of 13 months. A child psychotherapist colleague met with Nadira every three months to review her experience of the observation. My observational work was supervised by a consultant child and adolescent psychotherapist with specialist experience of this field. After Rahan moved to his adoptive home, I carried out follow-up visits to Nadira and semi-structured interviews with other professionals to evaluate their experience of the intervention. I then analysed the data using grounded theory methods (Wakelyn, 2012).

From the outset, the observation embodied the valuing of continuity, structure and attention. It proposed a regular routine that could continue as long as the foster placement lasted, and was open to the possibility of continuing in the adoptive home. It combined a focus on the moment-by-moment experiences of Rahan and of Nadira as his primary carer with the keeping in mind of the separation that would eventually take place between Rahan and his foster family.

Rahan's first year of life

Rahan was suggested as a potential subject for the observational research project during my first meeting with supervising social workers to introduce the project. This unexpectedly rapid recruitment of a subject was welcome, as opportunities to study the development of an infant placed in care at birth are relatively rare. But it did mean there was less time for me to get to know the social workers who might be involved and their working patterns.

Fourth contact with supervising social worker

> It is only when Anne (the foster carers' social worker) tells me the baby's name that I remember that I need to obtain the consent of his social worker for him to be involved in the project. Anne does not know his social worker and suggests I ask the foster carers who she is.

Although the research protocol was fresh in my mind, I had lost sight of the need to meet with the baby's social worker. In retrospect, I thought this forgetting powerfully reflected my instinctual denial of the 'corporate parenting' of the baby I was soon to meet. However, a living link of emotional life and memory between Rahan, his birth mother and his foster mother had been held on to by his social worker, giving order and meaning to feelings and attachments.

Social worker meeting 2

> Daniela (Rahan's social worker), recalls Tamara, Rahan's mother, saying that she thought about Rahan most in the evenings and that this was when she felt particularly sad. Daniela links this with Nadira, his foster carer, noticing Rahan crying in a particular way in the evenings; she tells me that the foster family wonder if this is when his mother is thinking about him.

When I arrived to visit the foster family for the first time, to tell them about the project and to ask if they would consider taking part, I had my first encounter with Rahan.

First introductory visit to the foster family

> I go straight into the kitchen where Nadira is feeding Rahan. I feel I can't distinguish between the two of them, while at the same time the high pitch of her voice conveys something unattuned, anxiety... Rahan is staring past Nadira's face at the wall behind her as he sucks on the bottle. He looks foreign and strange, like a little old man, his features seem large and prominent, not joined up, and at the same time he seems somehow sunk into himself. I feel sad to think he is an ugly baby, and rather scared by the idea of observing him. I wonder where he comes from, where he can belong.

> Later . . . there is a sense of still-raw shock as Nadira describes how just after she had been approved as a foster carer, she had a phone call from someone she didn't know, telling her to 'collect a baby' the next day. At the hospital they asked her to wait outside while they checked her identity, then they passed the baby to her at the door of the ward. She was worried someone would be waiting outside to fight her or take the baby from her. As Nadira recounts the story of their first moments together, Rahan begins to cry.
>
> She lifts him up and holds him close, then lays him on the blanket and talks to him soothingly. His face lights up and his whole body quivers, he stretches up his arms and legs and face towards Nadira. I am surprised and moved to see that he seems to have come together; he looks more connected and his face and eyes have more colour. I feel drawn to him, and more hopeful. Nadira looks at him closely, and murmurs tenderly, 'Shall we sing to Jenifer? She hasn't heard you sing yet'.

My first impression of Rahan as a lost, disconnected being was transformed as he came together with Nadira and then became more joined-up himself. I felt in myself a shift from fear, disorientation and repulsion to hopefulness and curiosity; this helped me to be able to think and to link the present moment with his past and future.

I found it hard to bring my thoughts together after the first observations. Writing the notes took several hours for each observation and afterwards I felt physically and mentally exhausted. All my energy seemed to go into absorbing and gathering feelings and impressions, and maintaining the continuity of the observation.

Observation 1 (3 months, 1 week)

> Nadira kneels next to Rahan and kisses him on both cheeks; he moans, and then is very still. She lies down close to him and says she doesn't know what he wants right now. Is he hungry? Or sleepy? She looks at him, wondering.
>
> . . . After the observation and writing the notes, I feel physically and mentally exhausted and fall into a deep, dreamless sleep.

During the early stages of the observation, it was only in supervision and in the later process of analysing the material that I could begin to make connections and think. Over time, as the observation becomes established, Nadira helped me to make links, to join up the Rahan of today with the Rahan of last week. She was able to link in her mind with social workers who could hear what she said and were able to recognise and acknowledge her mothering.

When Rahan made developmental advances, the temporary nature of his relationships became uppermost in my mind. I was filled with feelings of

foreboding, a sense of the most important things being 'all up in the air' that overshadowed relief and pleasure in his development.

Observation 11 (5 months, 3 weeks)

> Nadira points out to me how Rahan now sits sturdily and confidently upright. She places a basket of toys in front of him and tells me now he can choose and take out the toys himself. He pulls up the bedcover underneath the basket so that all of the toys spill out. He does this again and again. The thought of the wrench of his having to leave her keeps coming into my mind; I feel a sense of dread.

During the period when possible adoptive families were being assessed for Rahan, there was a feeling of bleakness as he roamed from one room to another, as if he were asking, 'where is my place, where do I belong?' or 'who am I looking for?'

Observation 31 (11 months, 2 weeks)

> Rahan wanders in and out of the upstairs rooms in a kind of restless, circling roaming.

As the observation progressed, I had little direct experience of joining-up between Rahan's social worker and Nadira's supervising social worker. Perhaps exposure to 'secondary trauma' and the burden of their large caseloads may have resulted in a blunting of the capacity to keep connections going and to hold their importance in mind.

Observation 29 (11 months)

> The observation has been arranged to coincide with the LAC review. Anne (Nadira's social worker) does not attend, while Daniela (Rahan's social worker) has been replaced by a student social worker. It happens that her name is almost the same as Rahan's. I catch myself hoping this might mean there could be some kind of connection between them.

In the final month of the observation, as the planning for Rahan's adoption took shape, my countertransference was one of being blanked, lacking a voice that could be heard in the professional network. Uncertain whether I would meet the adoptive family, not knowing if I would see Rahan again, I found myself 'too full' of anxiety and preoccupation:

17th contact with social worker

> I contact Daniela to discuss how I could talk with the adoptive parents about the possibility of continuing the observations of Rahan in his new home. She tells me

> *"The schedule is too full"*. The idea that the continuity of the observation could be helpful for him has got lost.

I felt a sense of barely contained panic and disarray during the last observations:

Observation 33 (12 months)

> Thinking about what it means for her, and for them as a family, to know that Rahan will leave soon, Nadira says, *"part of our heart is ripped"*-she corrects herself and says, *"goes away with him"*. She says they will all miss him, she will miss him. When there is a knock at the door, I immediately think it is someone coming to take him away.

I was moved and encouraged when, in the penultimate observation, Rahan repeatedly threw down and retrieved a toy that had become a transitional object for him, and held it close. His play made me wonder if he could now hold an object in mind and retain a sense of himself being held in mind, of being lost and found again. I had a strong sense of the importance to him of my witnessing this, as he watched my face intently throughout this play sequence.

Observation 36 (12 months 3 weeks)

> Rahan plays a slow game of peek-a-boo with me, which feels serious and enquiring. He brings the duck toy to me, watching me carefully, and gives it to me and takes it back many times. Then he throws it down on the floor, picks it up, and holds it close, embracing it in both arms and burrowing his face into it.

Alongside the planning for Rahan's adoption, which felt somehow at once unimaginably slow and unbearably quick, his progression from the sequestered inside rooms of the house, where his first months with Nadira were spent, to the transitional spaces of the hall and porch, and then to the outside space of the alleyway, felt orderly and methodical. This seemed to reflect a graduated progression from the intimacy of the foster mother-baby dyad to the world beyond the family that Rahan could perhaps return to in his mind. This graduated progression seemed to rely on and reflect Nadira's working over in her mind of the eventual separation between herself and her foster child.

Observation 32 (11 months, 3 weeks)

> Rahan stands looking over the board Nadira has placed to enclose the porch. He looks comfortable and sturdy in blue shorts and T-shirt. He looks into the alleyway in front of the house where the next-door children are running up and down. Nadira tells them not to move the board otherwise Rahan will go out. . . .
>
> He clings to Nadira's legs and she sits on a little stool and takes him on her lap in the hall. She tells me this is a nice cool and airy place when it's so hot outside. Rahan lies

comfortably on her lap, her arm firmly around him. She holds him closely, he sucks with concentration; they are quiet and still.

A little later, he slides on to his bottom and sits on the floor collapsed against a cupboard. Nadira takes him upstairs where the curtains are drawn against the hot sun. She puts him in the cot where the children take it in turns to play with him. Dina (Nadira's 7-year old daughter) climbs into the cot and plays 'this little piggy' with him.

Observation 35 (12 months, 2 weeks)

'Rahan goes up and down the alleyway with the boys from next door, they kick the ball for him and he follows it as it rolls. He goes in and out of the house again and again to see Nadira using the hoover. When she has finished, he goes up to the hoover, and touches it, smiling proudly and looking round at us.

Later on, Nadira tells me about her meeting with the adoptive parents. She says, ''All that time we were thinking about it and expecting it; and now I am thinking: 'it is happening now'.

The transition from the foster family to the adoptive family

Rahan's sudden arrival as a new-born baby reverberated in the foster mother's mind. Something of this sudden quality seemed to be kept going in the thinking about his adoption: the foster family heard that, 'he could go at any time'. While this was not literally true, each stage in the adoption planning process seemed to bring new shocks. It became increasingly apparent that there was a risk of Rahan's move to the adoptive family becoming a repetition of the first unmediated transition from his birth mother to his foster mother, itself perhaps a reverberation of troubled family dynamics that had led to him being taken into care. There was little time for the foster family and the adopters to get to know each other. The value of continuity, recognised in principle, proved difficult to hold on to in practice. The idea, mooted early on, that I would offer to meet the adoptive family and explore the possibility of continuing the observation in his new home, potentially providing Rahan with an additional element of continuity in his life, could not be broached. I understood that an idea was uppermost in the professional network, that a 'clean break' was needed, and that there should be just one final meeting for Rahan with his foster family once he had settled into the adoptive family.

Although my role as Rahan's observer was valued by the foster family and the social workers, I had found it hard to find a place for myself in the professional network. Voicing my thoughts and feelings during this last stage of Rahan's foster placement meant that I was acting as an advocate for the parenting he had received in the foster home and for the 'going-on linking' that I had seen to be

crucial in his development. He was now 13 months old, sturdy, rosy-cheeked, and lively, but I also held in mind a Rahan who could become unreachable and unjoined-up when not held together in his foster mother's attention. I think it was the observational, lived experience that I was able to draw on and communicate to his professional network that convinced them of Rahan's need for a more integrated transition and for a greater degree of continuity between his foster and adoptive homes during the period of his move. In follow-up visits with the foster mother, I heard of a growing closeness between the two families.

Findings and limitations

I found that the therapeutic observation of a looked-after infant was feasible, acceptable to the foster carers and could be sustained for 10 months up to the point of adoption. Consistent links with the social work network proved difficult to maintain and it was not possible to continue the observation in the adoptive home, but professionals in the multi-agency team around Rahan responded to semi-structured interviews after the observation was completed.

In grounded theory methodology, themes and categories are extracted from the data through a process of coding. Analysing the research data, I identified two contrasting types of organisation affecting individuals, myself included, and groups, each having their own spiralling effects: a 'virtuous' circle that I have called 'developmental organization', and a vicious circle that I have called 'trauma-driven organization' (Wakelyn, 2011). 'Developmental organization' is characterised by what I have called 'Matrix' dynamics. This is when connected-up emotional and organisational functioning is focussed on the child's experiences and needs, supports foster carers in their contact with painful emotional realities, and helps social workers to remain reflective despite the pressures of conflicting priorities and excessive workloads.

'Trauma-driven organization', in contrast, is characterised by catastrophic breakdown and fragmentation ('Tornado'), dissociation ('Machine') and suspended animation ('Limbo'), dynamics that create disconnection within the self and in groups. Contact with emotional reality is lost because people are 'beyond feeling' and cannot come together or think. Vicious cycles of dysfunctional communication escalate internally within the self and externally within groups and organisations, bringing about re-enactments of previous trauma and an atmosphere in which knowing about vulnerability and learning from experience are not possible.

Discussion

Attention combines the relatively passive function of receiving or absorbing with the more active function of gathering and bringing together (Houzel, 1999; Freud, 1911). Bion ascribes a dynamic intrapsychic significance to attention as

the matrix in which the elements of the psyche may come together and combine into a coherent whole (1970). A core tenet of the therapeutic observation literature is that the absorbing and gathering functions of attention facilitate integration. Receiving evacuations allows them to become projections and is the beginning of containment or alpha function (Bion, 1962). For example, Hall (2009) describes how she received and integrated the impact of being shut out and having to wait in an empty room during her mother-and-baby observations. Tolerating an emotion communicated in this way provides regulation, making the emotion less overwhelming, and providing an example of feelings being sustained and thought about, and thereby becoming meaningful.

A primary function of the therapeutic observation was to receive and absorb impressions, spanning from fleeting, momentary sensations to grosser shocks. My first impressions of Rahan as a lost baby, unheld and ungathered together, and of him and Nadira as isolated and alone together, but not in contact, changed fundamentally as Nadira talked over the impact of her first meeting with Rahan and I listened and watched. They came closer and took on the shape of a mother-baby couple and Rahan himself became more gathered together and began to look more like a baby.

I came to see parallels between the powerful experiences of scattering and fragmentation that predominated at crucial moments of Rahan's life in care and observations of premature babies described by Negri (1994) and Lazar and Ermann (1998). Observers in special care baby units were unable to bring thoughts together in mind or in a sequence. Their countertransference responses were often somatic, and could not be brought into consciousness and become thoughts until they were mediated and processed in the seminar group. Another parallel with observations of premature babies was the sense of ugliness, together with feelings of repulsion and guilt in the observer that I registered in my first visit. Over time the observation encompassed a gathering together of the disparate and the fragmented that facilitated integration. The process of psychological birth brought with it a move from ugliness to beauty.

Applications of the research

Referrals of infants and young children to the specialist mental health service for looked-after children have increased following the research project. Some referrers request a mental health perspective to contribute to planning placement moves for infants and young children. Our interventions are multi-faceted. Therapeutic observations, professionals' meetings, sessions with birth parents, nursery or school observations, and 'play support' sessions for foster carers and supervising social workers inform guidance in relation to future care, mental health risks and therapeutic provision.

Resource constraints preclude once-weekly observations, but the method has proved adaptable to a range of clinical needs. A three-year-old boy was referred with concerns about post-traumatic distress, developmental delay and autistic

features following a series of traumatic placement disruptions. Fourteen observations in the foster home and in the nursery were carried out over a 10-month period, together with six-weekly professionals' meetings. This child's quasi-autistic features resolved, and his foster carer was able to attune to his particular needs. A girl aged two who came into care at the age of 18 months was referred after she was observed hitting herself and telling herself she was 'bad, all bad'. Clinicians met with her foster carers and carried out a series of observations in the foster home and in the nursery, continuing the visits in the new foster home and nursery after the first placement came to an end. Observational work was followed by play support sessions in the clinic for the child with her new foster carer that allowed her rigid defences to come into focus and be thought about. This work led into a referral for intensive psychotherapy which was supported by the foster carer and social worker. For three-year-old twins who were adopted following severe physical abuse, therapeutic observation in the foster home was combined with professionals' meetings and sessions for the foster carer, followed by meetings with and telephone support for the adoptive parents over the next year. Two years on, the twins are able to trust and turn to their adoptive parents, play together and enjoy nursery.

Social workers have also requested consultation in relation to transitions for babies and young children moving from foster care to adoption. Feedback on the consultations suggests that a space to reflect on anxieties about what are often intractable dilemmas, with only a 'least bad' possible solution (Goldstein, Freud, & Solnit, 2000), has been particularly helpful for social workers for children whose pre-care history was marked by extreme trauma and violence. Infants with a care history like Rahan's, who have developed close relationships with their foster family in their first year or years of life, also present particular dilemmas for social workers when adoptive families are found for them. While individual circumstances determine the planning of each child's move, there has been interest in the idea that in principle, the first months of an adoptive placement constitute a transitional period when children may need, where possible, an experience that is 'both-and' rather than 'either-or' (Lanyado, 2003).

Further research

Observations of children entering the care system because of child protection concerns would provide useful comparative studies to this account of an infant fostered from birth. An observational study following a social worker and the professional network through the vicissitudes of a child's life in the care system would also provide an invaluable counterpoint to observations of infants with their foster carers. The project has also highlighted a need for practice guidance on transitions from foster care to adoption.

A question that I should like to address in further research is whether therapeutic observation could be demonstrated to promote 'developmental organisation'. In semi-structured interviews carried out after the observation

ended, most respondents considered that it would inform understanding of foster care, the support needed by foster carers and planning of transitions. Some respondents thought my involvement in the planning of Rahan's move to adoption had been helpful for him; others felt it would have been more helpful had the observational work been more integrated within the professional network. The research project may itself have exacerbated a tendency to disconnect in the professional network, perhaps by being perceived as excluding other professionals involved in Rahan's care. These issues have been noted in the applications of the research described above.

Conclusion

Carrying out clinical research has enhanced my role as a child psychotherapist in a specialist service for looked-after children. Rustin (1991) suggests that a 'research state of mind' can bridge gaps between practitioners and researchers, mitigating burn-out for front line workers in social services and mental health. The therapeutic observation that I was fortunate to conduct with Rahan and his foster family put the process of infant adoption under a microscope and highlighted elements of the universal experience of babies in the care system.

The observation allowed me to come into contact with the powerful and intense emotional experiences of this foster mother and baby, and with reverberations of the impact of Rahan's move into adoption on the foster family and the professional network. The week-by-week grounding in the development and vicissitudes of an infant in foster care gave me a more experiential understanding of the often unfathomable dilemmas faced by social workers responsible for the youngest children in care. My experience was that therapeutic observation is well suited to provide a degree of background continuity and mindful containment for infants and young children facing inevitable disruptions in external and internal aspects of their care.

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