“Momma bear wants to protect”: Vicarious parenting in practitioners working with disturbed and traumatised children

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Abstract

Practitioners working with disturbed and neglected children and young people face many practical and personal challenges, including countertransference and secondary trauma reactions. One under-explored area is the practitioner requirement to negotiate with children's parents and to process feelings towards both parents and children. We explore the experiences of female counsellors and psychologists working with children and young adults in the UK mental health care sector, using an inductive thematic analysis. While participants spoke positively about their vocation and satisfaction gained from acting as an agent of change in young peoples' lives, they also related highly intense emotional work and traumatic accounts, using powerful metaphors to convey the impact of hearing and processing stories, indicating vicarious trauma effects and a strong parental invocation in therapists, including maternal feelings toward some children ("vicarious parenting."). Some parents were cast as potentially harming a child and obstructing the professional's work. Our paper fleshes out vicarious parenting as a particular form of countertransference.

Introduction

Practitioners working with disturbed and neglected children and young people and their families face many practical and personal challenges, such as busy workloads, comprehending traumatic stories and operating in emotionally demanding environments with children and their families (Rössler, 2012). An extensive body of literature seeks to explain and document health and wellbeing impacts on such professionals (Curry, 2019), often toward developing strategies to help them work with complex relationships more effectively (Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015). This is, however, a difficult field of work with areas that are yet to be fully explored. For example, the impact of parental behavior on children's mental health is well known (Hicks and Stein, 2013), yet the problems pediatric mental health practitioners face in negotiating parents of traumatised children, and in processing their feelings toward them, have not been widely discussed. To remedy this gap in the literature, we explore data from interviews with six counsellors and psychologists who work with disturbed and neglected children and adolescents, focusing on the unique rewards

and challenges of their work. Small scale studies can offer new ideas and insights that can be used to inform future practice (Hernandez-Wolfe et al., 2015; Hochschild, 1979). Our aim is to contribute to a clearer understanding of issues facing pediatric health and social care workers in the contemporary field toward supporting them in this work (Hernandez-Wolfe et al., 2015).

Demands of work for health professionals

Research done in areas of the "people" sector indicates that intensive face-to-face work is demanding and potentially stressful (Biron, Brun, Ivers, & Cooper, 2006). Literature on stress and burnout is somewhat polarized however, with psychologists inclined to cite psychological characteristics as the primary contributors to negative health outcomes (McCann & Pearlman, 1990; Ogino, Takigasaki, & Inaki, 2004), and social scientists focusing on the work environment and organizational structure. Back in the 1970's, Arnie Hochschild critiqued social psychology for its tacit assumption that emotion is an individual concern and not governed by social rules or affected by social contexts, including the work environment. She coined the term "emotional labour" (Hochschild, 1979) to describe the expectation that service workers regulate their emotional displays during service encounters.

Assessing what distinguishes emotional labour from other forms of work feelings has since been the matter of much research and debate. Most authorities agree that emotional management at the behest of others can have negative consequences, both for the actor and those for whom the emotional display is intended (Ashforth & Humphrey, 1995; Wharton, 1999). Sustained emotional labour has been linked to burnout, a state of chronic stress, exhaustion and emotional disengagement (Schaufeli, Leiter, & Maslach, 2009) considered common among those in mental health services (Morse et al., 2012). Other writers have, however, argued that particularly in the care professions, professionals may choose to

cultivate emotional displays such as compassion and empathy, and gain personal satisfaction in the process (Fixsen and Ridge, 2012).

Countertransference

Among the psychological theories used to explain the complex relationship between practitioner and patient, Freud's (1926) theory of "countertransference" is one of the most recognized. Both Freud and Annie Reich's conception of countertransference was as a pathological obstacle to therapy (Burke & Tansey, 1991) but over time the concept broadened to encompass a practitioner's total reaction to a client or patient in a therapeutic situation. Following on from Paula Heinmann's (1950) classic contribution to countertransference, more positive interpretations of countertransference emerged, suggesting that when properly understood and managed, transference and countertransference can provide valuable insights into the patient's inner world (Racker, 1968) and positively inform patient care and patient management (Yakeley, 2018).

Heinmann (1950), by portraying countertransference as a creation of the patient's own personality, sheds new light on the potential for non-erotic attachment to arise in therapists working with patients/clients who may be consciously or unconsciously seeking a relationship beyond accepted physician/patient boundaries. The term "countertransference love" for example, while first used to indicate the presence of erotic attachment feelings in the therapist (Koshes & Sari, 1991), can be extended to include intense (non-sexual) feelings of maternal love on the part of therapists toward children and adolescents (Sherby, 2009). This type of affect may be familiar to those working intensively with children, yet the consequences of developing strongly maternal or paternal feelings in paediatric staff has received surprisingly little academic attention, leading Rasic (2010) to call for the renewed study of countertransference and its effects in the field of child and adolescent psychiatry.

Classical theories of countertransference explain the two-way transmission of emotion between client and practitioner, yet they say less about extraneous factors which can exacerbate or moderate unpleasant or negative feelings. “Indirect” or opposed to “direct” countertransference might, according to Racker (1968), include a third party such as a patient’s friend or relative (Brandell, 1992; Racker, 1968). The lack of early studies focusing on countertransference effects in psychotherapists working with children, for example, has been attributed to the difficulties therapists have in acknowledging the emotional reactions evoked in them by the child’s parents (Kohrman and Fineberg, 1971). Berta Bornstein, one of the first to write about countertransference in child treatment, recommended caution on the part of the therapist concerning their involvement with a parent, as unexpressed “counter-aggression” could result in the erecting of unsurmountable barriers to the child’s treatment (Bornstein, 1948, p.693). Children, Palombo (1985) concludes, arouse a defensive, parenting response in therapists, who are then obliged to be in contact with the real parents, further complicating the treatment process (p.40). In the case of child or adolescent residential care, an intensification of the countertransference potential is, according to Ekstein et al. (1959) highly likely, as staff inevitably assume the function of a parent in providing care for the child. For those (predominantly female) residential staff working with disturbed children from unstable or traumatic circumstances, identification with the role of the “good parent”/ “loving mother” and the living out of a “helping fantasy” may create initial therapeutic optimism, anger toward the “bad” natural parent and inevitable disappointment when a treatment plan is disrupted or fails to work out (Ekstein, Wallerstein, & Mandelbaum, 1959).

Vicarious trauma

While earlier psychoanalytic interpretations of transference and countertransference made reference to childhood trauma (Brandell, 1992), it was not until the early 1980s that the full

impact of trauma on the child, and the possibility of “vicarious traumatisation” in those working with them, gained credence in the psychiatric literature (Terr, 1985). The term “vicarious trauma” or vicarious traumatization (VT) came to refer to a secondary trauma reaction that followed repeated exposure to clients' traumatic experiences or materials by way of countertransference (Pearlman and Saakvitne, 1995). Here, secondary traumatic stress (STS) is defined as set of psychological symptoms that mimic post-traumatic stress disorder but are acquired through exposure to persons suffering the effects of trauma (Baird & Kracen, 2006). While differences may exist between VT and secondary trauma, for the purpose of this study we will use the terms interchangeably. First linked to psychotherapy work, it is now recognized that VT can occur in any area of health and social care (Devilly, Wright, & Varker, 2009) or in anyone work with trauma survivors or sufferers such as lawyers (Byrne & Maguire, 2017).

Research suggests that VT does not necessarily relate to the specific nature or severity of the trauma but manifests itself in various ways depending on the client and situation (Ben-Porat & Itzhaky, 2009). An association has, however, been identified between the levels of experience and support of social workers and the severity of VT with increased social support and greater experience levels predicting less severe examples of trauma (Michalopoulos & Aparicio, 2012). A study focusing on social work students found these inchoates to be at greater risk of experiencing VT than their more experienced colleagues in previous studies. Other risk factors identified in the study included age, experience, gender, and placement in a child welfare setting (Knight, 2019), i.e. similar to burnout risks (Hamama, 2012). Such effects are significant as they can lead to harmful changes in professionals’ views of themselves others and the world (Baird & Kracen, 2006).

Despite the literature supporting the view that mental health professionals experience secondary trauma in its various forms, limitations remain in the broader literature in terms of

conceptual clarity and an understanding of the consequences of working with clients who have been traumatized. As identified in relation to emotion work, a growing alternative literature seeks to re-establish the positive effects of altruistic care work, such as "compassion satisfaction"- the positive feelings derived from helping others through traumatic situations (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). A more recent concept, that of vicarious resilience, suggests that therapists can be inspired and buoyed up by the strengths of their clients, leading to an increased sense of hope and optimism in the therapists themselves (Hernandez-Wolfe et al., 2015; Silveira & Boyer, 2015).

Working with challenged children

Healthcare and social workers, working with disturbed and/or traumatised children and their distressing experiences, are presented with a specific set of challenges. Young clients may live in situations involving maltreatment, abuse, and violence (Silveira & Boyer, 2015). Child survivors of complex trauma can present with higher levels of generalized behaviour problems and trauma-related symptoms than those who experienced acute non-interpersonal trauma or trauma that begins later in life (Wamser-Nanney & Vandenberg, 2013). In studies of mental health and social service staff, exposure to more vulnerable and traumatic situations related to children has been associated with an increased risk of burnout and secondary trauma (Ben-Porat and Itzhaky, 2009; Sprang et al., 2011). Core competences and strategies to support staff include: knowing the signs, symptoms and risks of secondary trauma (ST) required by supervisors, encouraging employees to share emotional experiences in a safe and supportive manner, cognitive-behavioural strategies, improved social support, and various self-care strategies, better management of workloads and more support from peers (Cohen and Collens, 2013; Hernandez-Wolfe et al., 2015; NCTSN, 2012).

Aspects of the work, such as organisational pressures and constraints and having to negotiate and work with the parents of young clients, should not be overlooked in this discussion. Challenged children are often neglected children, with cases characteristically involving the breakdown or absence of a relationship of care. Indeed, the pivotal role of parenting/parental mental health on the mental health of the child is well recognised (Hicks and Stein, 2013). The therapeutic response therefore needs to focus not only on the child themselves but the relationship difficulties between parent and child. This may manifest either as an unwillingness or inability on the part of the primary carer to offer reliable, adequate care, or as broader relationship difficulties within the family (Turney & Tanner, 2002). As indicated in our previous discussions of countertransference and VT, a common dilemma for those working with neglected children is the forming of emotional attachments, with care staff assuming a vicarious or surrogate role similar to an ideal parent surrogate in terms of sense of responsibility for the welfare and happiness of the young person in their care. We now turn to our work, which aims to expand upon existing knowledge and understanding of this sensitive and under researched area.

Methods

We used an inductive, qualitative method (Charmaz, 2005) to collect and analyse data from semi-structured interviews with six female professionals worked with challenged and neglected children and young people in different capacities. For logistical reasons, the data set was too small to achieve data saturation, however we used a form of stratified purposive sampling to maximize the diversity of our all-female sample (Fixsen & Ridge, 2012; Lohr & Lohr, 2019). Participants deemed to be under the umbrella term ‘child and adolescent mental health worker’ were approached via email. Participants under 21 years were not included. Our all-female sample was incidental but reflects the gendered orientation of much pediatric

care work. In hindsight this gender consistency within a small sample made for a more nuanced exploration of phenomena such as attachment and countertransference effects within participant narratives. After one participant decided to withdraw, the final cohort consisted of six females between the ages of 21 and 60 years, currently working with young people with mental health disorders in different areas of England and Wales. Table 1 below provides information on participants, whose real names have been replaced with pseudonyms for confidentiality purposes. We emailed all invited participants copies of the participant information sheet and consent form (as approved by the University Research Ethics Sub-Committee) to read and complete prior to the interview. Interviews were conducted in private place or by telephone and lasted 40-70 minutes.

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The first author used an 8-question topic question guide with prompts, otherwise they endeavoured to establish a good rapport with participants in a short space of time and encouraged participants to talk freely about their experiences (Denzin & Lincoln, 2005). Participants were questioned about why they had chosen to work with younger people, the mental health problems they frequently encounter; work challenges and how they manage them, any critical incidents and traumatic experiences and; support and training. Following the initial interview, we amended the protocol and developed additional probes to explore specific topics, e.g. transference effects, more comprehensively. After the interview, the first author thanked participants and provided a debriefing sheet, which included contact details of mental health charities should any personal issues arise for participants.

We chose thematic analysis (TA) due to the flexibility of this approach, allowing minimally organized, richly descriptive data to be interpreted in a lesser or greater degree, without - as in Interpretive Phenomenological Analysis (IPA) - being bound by a pre-existing

theoretical framework (Braun and Clarke, 2006; Smith and Osbourne). We utilized this approach both to "reflect reality and to *unpick or unravel the surface of 'reality'* " (Braun and Clarke, 2006, p.81). We were guided in our analysis by Braun and Clarke's (2006) 6 key stages of TA: familiarizing; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing a report (Braun & Clarke, 2006). A modified constant comparison approach was also used to allow for the emergence of a deeper understanding and insights into our findings (Fixsen & Ridge, 2012; Strauss & Corbin, 2015). In stage one, the first researcher listened repeatedly to the audio recorded interviews before they were transcribed, read and reread the transcripts, and with the use of color coding and mapping generated initial codes and themes. Tentative concepts and themes arising from the data were identified and noted during these initial coding stages. The second author then independently read the transcripts and engaged in multiple discussions with the first author concerning the generation of new open and axial codes and refining or eliminating initial ones. The third author who was a supervisor on the project, assisted at different stages of the analysis, in particular in theory building. Finally, we re-inspected the full data set and used NVivo maps to examine our findings in different ways.

Results

Emotion effects

For our cohort of health professionals, the emotion impact of working with vulnerable, often neglected children could be "really intense." As Chloe explained, "you see and hear things that are, just awful." The emotionality of it could lead participants to "almost shut down. It's a weird feeling." You wanted to "make things better" but inevitably there was a limit to what you could do and that "leaves you feeling really helpless." For some in the cohort, working

with children brought out a protective, even maternal, instinct (e.g. "I want to take them all home with me"), which could test professional boundaries. As Amanda explained:

> [Working with children] . . . makes it more personal . . . I don't think I've heard of a psychologist who is a parent themselves who hasn't had it happen . . . when the mum wakes up . . . (laughs) and "momma bear" wants to protect. Sometimes you have to remind yourself your role isn't . . . mum. To separate that personal and work boundaries is difficult.

Participants used strong metaphors and descriptions to depict the strong responses their work could trigger in them; e.g. "Little ones can absolutely crush you sometimes." The "totally innocent naivety" of these neglected children left you with "a huge sense of responsibility." The way that these children accepted their distressing experiences as normal was "heart-breaking", e.g., "This kid doesn't know how 'not ok' these experiences have been . . . they think this is normal." Amanda spoke of the disbelief and shock she felt when hearing accounts of child abuse during her work with trauma survivors; "How one tiny human [can] have gone through so much . . . I can feel the adrenaline go in my body . . . the skin starts to tingle, and my big muscles start to twitch." Similarly, Elizabeth explained how "There have been times where I've left a session actually physically shaking and tearful and feeling utterly discouraged -what can I do?"

Case-load pressure meant there was not enough time to process emotional reactions; e.g., "I've only got 15 minutes, it's quite tough to kind of turn myself around . . . because I have to be fully present with the next one." Although you tried to distance yourself emotionally, it could feel very painful at times. Participants themselves were aware of this countertransference effect, but Sarah spoke about trying not to "take it on board personally." Perhaps due to her type of training or supervision, Adlerian therapist Elizabeth was able to

directly link work with her young clients with painful feelings and events from her own childhood:

> Because of my own experience, that gets sort of retriggered and parallel. So, for example, what I find difficult is if somebody's parents, mother in particular, reminds me of my family, my mother, or my father and reminds me of difficult times . . . that definitely is transferred, you feel it, you feel their pain."

Still, participants grow more accustomed to the demands of their work in time and it was easy to overlook the personal toll of working with traumatised children. As Amanda explained it; "you forget how explicitly traumatic this work can be sometimes, because you get used to it and you manage it . . . the sponge sucks it all up and then wrings it all out, and you start all over again."

Negotiating parents

Of the various factors that participants had to negotiate, dealing with children's parents appeared to be one of the most vexing. Some parents supported their child through treatment, but in many instances, children ended up in the care system, often in foster care. Elizabeth described the emotional impact of working with fostered children and witnessing them being left to fend for themselves once they had reached so-called "adult" status: "It's really hard to feel that you're sending them out completely unprotected when they reach . . . 16." Overall, participants found the role of parents in their children's treatment to be obstructive. Many parents responded, "in a really unhelpful way," and were inclined to dismiss therapy work, through lack of understanding and education, though denial, or simply an absence of desire to help. Some parents, "just won't engage, or they think that, it's all airy fairy, hippy dippy

bollocks." Staff then faced the additional challenge of motivating and educating parents on their part in improving their child's mental health. Staff frequently had to rely on the parents to bring their children to sessions, and this could be a problem, "[If] they don't want to bring them, it's quite a challenge with parents actually."

One of the reasons children who came to service was because they lacked the family resources or external resources "to keep them safe." Participants were painfully aware that, after a session, some children had to, "go home to face the parent's anger." If the parents knew their children were having counselling, practitioners were aware that the children could be asked about a session. If parents resented therapy, children were left in the middle torn between staff encouraging therapy and parents not encouraging or allowing them to attend. Children could then miss out on the therapy or were left with little to no support to manage the complexities and challenges of issues raised in therapy. Knowing that the children were being sent back to trauma-ridden homes and unsupportive parents could create anger and sadness in participants; "I felt so sad for the children, who had to go back to these horrible families, to the violent, you know, step mother who locked up the food cupboards" *(Elizabeth).* Cases involving domestic violence and sexual abuse were, participants agreed, "very challenging to deal with." Penny recalled a very harrowing child bereavement case, in which the deceased father had later been suspected of child abuse; "Dad had been very domestically violent to all of them, but it would appear that this girl also had his special interest." Penny described how some children were acting as carers for their heavily medicated parents yet received no help or support from them with regards to their own mental health:

> They're [the parents] kind of "maintained" so they don't commit suicide, but they might be cutting up their arms in front of the kids or erm . . . taking, self-medicating .

> . . whatever that might be with the kids around . . . how do you manage a situation like that? . . . There's no chance of things becoming any better for the parent, that's one of the most difficult things.

Not being able to deliver the desired level of care was dispiriting when one could see what needed to be done, e.g., "There are moments where I've felt really, really angry at parents." Participants were not entirely unsympathetic to the parents and their problems, however. They recognised how hard it could be for parents to comprehend or process their child's mental health issues. Sometimes parents wanted to help but simply didn't know what to do, and were feeling "powerless," "really, really scared" and "anxious." Both Amanda and Chloe felt that the majority of parents would themselves benefit from (individual or family) counselling. Indeed, where staff had worked with or referred the parents to counselling services, it could make a strong impression on the parent; "you see the parent really engage with the work, and that's really exciting, that's really fun." (*Amanda).*

Impact on personal/ home life

All participants described the impact that experiences and difficulties at work had on their personal life. One factor was the exhausting nature of the work, especially for those new to the job. As Rihanna explained; "I just needed to lie down, have a really quiet time . . . it has kind of stopped us from doing more stuff." Powering through the workday was a common tactic of participants, however the day-to-day stress of the work took its toll; "you're really working hard, and you're really stressed and keep going [and] going and when it gets to Christmas holidays you get sick."

Elizabeth found the impact of her work very emotional, and would sometimes cry about it in the privacy of her own home "I went home in tears . . . I felt so sad for the

children." Despite their attempts to keep work and home separate, the effects of work did still spill over into relationships with family and friends. For Penny, the demanding nature of the work left her with less to energy for family life: "It can be draining obviously, I mean coming home and dealing with family life, and you've got less to go around, a lot less to go around." Amanda spoke at length about her sessions with one very traumatized young adult; "everyone kicked her out...you know including her parents…dismissed her and rejected her." At the time she had found it very "tricky" to separate out her feelings for this young client from those for her foster daughter:

> "Sometimes they reminded me of each other…so there was a little bit of blurring boundaries for me with those two...I had to be very clear in my head about which child was which…that this is my emotional…home parenting role."

Reflecting of the pressures of this work, Amanda saw a possibility that some people could turn to unhealthy coping strategies such as excessive drinking. However more useful forms of coping were also mentioned in interviews such as "watching crap telly," talking with friends, going for a run or singing. It was important for participants check in with themselves and not become totally immersed in the caring role; "It's that thing isn't it? You look after everyone else, but you forget about yourself."

Organisational challenges and support

Most participants who had worked, or were currently working within NHS, found the organisational structure challenging and unhelpful. The constant throughput of young clients, along with the pressure to swiftly discharge those in their care, was one of the most stressful aspects of organisational work. Rihanna, for instance, had been expected to take on extra

clients due to the high demand for professionals, she had “been carrying about 24 or so. And that’s a lot for someone who doesn't have any experience in mental health prior to this role and hasn't got the right support and supervision.”

Working within tight time limits could make it difficult to build sufficient rapport to allow clients to fully disclose their feelings, and thereby work with them at a deeper level. Realistically “you’re just scratching at the surface” before children are discharged. As Elizabeth explained; “Many organizations only fund 6 sessions, so you have to be in there [making rapport with the client] right at the start.” Both professionals and young clients were under pressure to demonstrate fast results. As Chloe explained, “We do work towards discharging quite quickly. Sometimes that can feel a bit anxiety breaking.” These pressures could leave participants feeling “as if the kids are being let down.” The system itself could be under immense pressure to show results, even as it was collapsing under the strain.

Support that participants received in the form of training and supervision varied, however the reports were that supervision within the NHS system was inadequate. While working as a CAMHS nurse, Penny had been expected to travel 40 km to her supervisor, which “with the workload…wouldn't be feasible.” Similarly, Amanda had experienced problems in her previous CAMHS role, and had left there when she felt that, in a bid to save money, superiors were compromising the quality of care for clients; “The working conditions were so horrific that half the team left . . . morale plummeted.” In her new position as clinical psychologist she felt far better supported and was eager to provide regular supervision and support to those in her team. Knowing that there was a strong team to support you and being offered regular clinical supervision were seen as vital. Otherwise; “We will burnout. It’s not an ‘*if*,” it’s a ‘*when*.’ ”

As the manager of a young person’s counselling charity, Sarah was personally responsible for arranging adequate supervision and support for staff but admitted that

achieving this was challenging. First, there was recognising the traumatic nature of the work and second, there were the financial constraints within which she had to work. Even though management put "an awful lot of support in place to keep them [staff] well enough, and healthy enough to be able to continually [manage the emotional challenges],' she had to weigh up all the cost implications, but didn't, "want my staff to be off sick because of distressing things they see and hear."*(Sarah).*

Rewards of the work

Despite the many challenges they faced, by and large participants enjoyed their work. Being able to intervene early in young peoples' lives was very satisfying; "you can get in there early before things get really bad." Because they were young and adaptable, "You can see young people get better even with such a short amount of time . . . it's really rewarding." (*Chloe).* Participants also believed their work to have long term value, because it focused on "prevention rather than cure" and pulled "people away from a path of psychiatry." You could also be "much more creative with little ones and teenagers than necessarily with adults:"

> There are some days where I kind of find myself lying on the floor with a little one blowing bubbles and thinking 'oh my god I actually get paid to do this!' (laughs), do you know? It's fun, I like going home occasionally covered in glitter from head to toe. *Amanda*

Discussion

We set out to explore the experiences of a small group of female counsellors and psychologists working with children and young adults in the UK mental health care sector. Of particular importance to us was identifying the unique challenges these professionals face in their day-to-day work and considering additional support mechanisms that could assist

them in this process. Our findings suggest the nature of their work to be gratifying but highly demanding. Participants spoke positively about their vocation and the satisfaction they gained from acting as an agent of change in young peoples' lives. Participants also recounted highly traumatic stories about children's lives, the considerable impact these narratives could have on them and the difficulties of separating work and personal life Also striking in our participants' narratives were the feelings of frustration and anger they felt for some parents and the distinctly maternal feelings evoked by the work. In this section, we discuss these points in more detail below and introduce our concept of a vicarious parenting role, which professionals working with vulnerable and neglected children might be inclined to adopt.

According to the literature, frontline mental health staff may experience varying psychological and somatic effects (Evces, 2015) as a result of repeated exposure to client suffering, including emotional distress (Trippany et al., 2004). Participants in our study used powerful metaphors and analogies to convey the physical and emotional impact of children's stories, e.g. "those little ones can absolutely crush you sometimes." Examples were given where feelings became overwhelming resulting in weeping or exhaustion, changed views on life and parenting, and the seeking of personal counselling for stress and anxiety. While descriptions and contexts differed, we consider our findings to be consistent with other work on vicarious trauma (Evces, 2015; McCann & Pearlman, 1990) and secondary traumatization in child and family welfare workers (Bride et al., 2007; Sprang et al., 2011). Participants spoke of having to hold on to challenging emotions as a result of insufficient supervision, arguing that its deficiency put health professionals such as themselves at grave risk of "burn out." These opinions concur with many published studies on emotional regulation and burnout in healthcare professionals, including child welfare workers (Salloum, Kondrat, Johnco, & Olson, 2015) and child welfare supervisors (Austin Griffiths, Whitney Harper, Patricia Desrosiers, 2019) and pediatric mental health workers (Mcgarry et al., 2013). Even

so, participants rationalised their work and to some extent regarded these risks as part of the job. As professional counsellors and clinical psychologists, participants in our sample appeared to have a high degree of awareness concerning the emotional side of the work and how it affected them. Nevertheless, knowledge of phenomena such as countertransference and burnout does not necessarily protect people from their effects. Participants were well aware that everyday life obstacles could prevent the adoption of, and adherence to, best practice. Inexperience in the field, demanding caseloads, poor organizational management and lack of supervision had each impacted on their work in different ways and at differing points in their careers. Participants also offered honest appraisals of their own inability to sometimes disassociate themselves from work and from the memories and emotions that the work triggered in them.

Vicarious parenting

While the unique effects on therapists and psychologists working with children are now widely recognized (Carr, 2015) including countertransference (Palombo, 1985) and secondary trauma or VT (Silveira & Boyer, 2015), few studies specifically look at the complex feelings evoked when working with vulnerable children, where parents frequently have to be taken into consideration. However, one study that looked at how child welfare workers constructed narratives with parents with mental health issues found that both professionals and parents assumed low parental culpability (Keddell, 2016). A different study found that, in cases of domestic violence and parental substance abuse, workers' assessments of parental responsibility for child maltreatment and concerns about child safety were heightened (Landsman & Hartley, 2007). In other words, professionals evaluate the fragility of both the child and the culpability of parent which is likely to influence their sense of duty and responsibility for their charge.

Our study uncovered a strong parental invocation in therapists in this kind of work (Bornstein, 1948; Ekstein et al., 1959). This effect was sufficient for one therapist to find it hard to separate out their feelings for a child they were treating with a foster child in their permanent care. As Bornstein (1948) indicated, unlike with other forms of emotional attachment, this imagined or "vicarious" parenting on the part of therapists can lead them to become particularly angry with the real parents, who are seen as potentially harming a child, obstructing the professional's work, or acting in ways inconsistent with how therapists would act with their own children. These territorial feelings run counter to the directives in paediatric health and social care literature that suggest a therapeutic response focusing not only on the child but the relationship difficulties between parent and child (Rigazio-DiGilio & McDowell, 2012; Turney & Tanner, 2002). They may, however, align with an institutional viewpoint concerning "good" and "bad" parenting (Ekstein et al., 1959).

Modern therapy has largely abandoned any notion that children can be considered in separation from their family and social context. For those working with, and experiencing strong sentiments for, and on behalf of, a child/adolescent however, gaining distance from their feelings for the child within the complex task of family healing can be difficult. For deeply personal reasons, care staff may assume (in their minds) a vicarious role similar to a parent surrogate. In the absence of pre-existing terminology, we have described this as a "vicarious parenting" role. By vicarious we mean parenting as experienced in the imagination of the therapist that takes or supplies the place of another (i.e. the parent or carer).

Implications for practice and policy

We see three main implications of our work for practice. Firstly, while vicarious parenting sits with existing theories of countertransference, including "countertransference love" (Sherby, 2009), by identifying and naming transference effects explicitly, means can be

found to better identify and engage with emotions evoked in therapists. Secondly, by recognising and naming specific feelings and reactions which arise in professionals during the everyday performance of their work, researchers and practitioners can consider where they fit with, or add to, existing knowledge. Thirdly, our work suggests the continued importance of looking at the therapist's experience in its entirety, including their sensitive position within the family and social context of child therapy.

In terms of future policy, our study highlights the need for greater recognition of the intense emotion work performed by practitioners working with disturbed and neglected children and young people, and the need for specific training concerning parental roles and more frequent supervision for newly inducted staff if burnout is to be avoided. We are aware that for our ideas to have relevance beyond our small study, our concept of vicarious parenting must be explored in different contexts, and we would encourage more attention to this topic in the future.

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