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FEEL THE PAIN AND DO IT ANYWAY

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Abstract: This article is a reflective account of the process of a social care worker's professional development over a span of 28-years, primarily working within children's residential care settings. It charts the author's journey with regard to his ability to cope with anxiety (pain-based fear) and to live "on the edge" in his professional practice. The author's personal experience as a young boy of the death of his father is identified as having caused pain-based behaviours for the author until such time as he faced the pain of this loss. The traumatic experience then became an asset in his direct work with children and young people in the role of a "wounded healer". The article introduces the concept of "vicarious confidence" and its critical role in leadership and supervision. Self-care is discussed and the concept of "system-trauma" is identified. The article also discusses the role of magic in social care and links this to neuroscience and brain MRI images. The article highlights the positive role pain can play in enabling workers to connect empathically with hurt children and young people and posits that if we are to care authentically then we must be prepared to experience pain.

Keywords*:* pain, risk, love, hope, stress, anxiety, vulnerability, empathy, self-care, confidence, vicarious confidence, supervision and residential care

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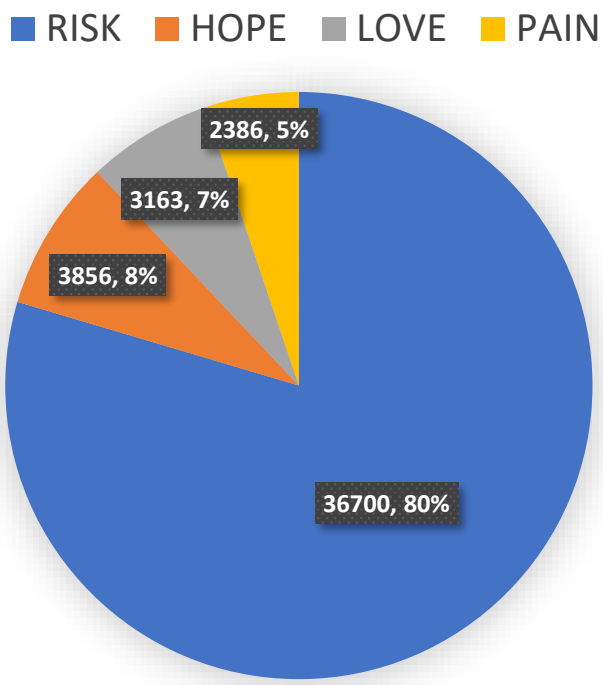
Pain is commonly perceived as a most unwelcome thing indeed. But what is this thing we all seek to avoid, minimise, or eliminate from our lives with such dedication and zeal? Is it a feeling, an emotion, a psychical thing, a neurological thing, or a spiritual thing, and is it contagious, hereditary, or culturally influenced? One could enter into deep discussion and analysis of ontological and epistemological matters in an attempt to determine just what this thing called pain really is, and if in fact it even exists as we conceive of it and what it means to different people.

The Oxford dictionary (https://en.oxforddictionaries.com/definition/pain) offers the following concise definitions: "Highly unpleasant physical sensation caused by illness or injury" and "Mental suffering or distress".

It is my current belief that pain, along with some other four-letter words such as risk, hope, and love, holds particular significance in the field of child and youth care work. An investigation of the frequency of usage of these words in the research and academic literature holds potential for illuminating the evolution of the professions of social care and child and youth care over recent decades. Adhering to the sociological tradition of unveiling the forces at play in order to learn from them, I undertook a literature search for the four words *risk, hope, love,* and *pain* in the published titles within four academic databases covering social care and child and youth care and two high-impact academic journals. The databases were: (a) Education and Resources in Education Index (Eric Subscription); (b) Social Services Abstracts (SSA); (c) Economic and Social Data Services (EDDS); and (d) Child Development and Adolescent Studies (CD&AS). The two journals were: (a) British Journal of Social Work (BJSW); and (b) Children and Youth Services Review (CYSR).

As seen in Figure 1, risk clearly dominates the field, with hope and love closely aligned in their usage, and pain the least used word in the literature. These findings support my practice experience where the concept of risk has become oppressively dominant over the past two decades. There is an unrealistic expectation that by the implementation of better management models, systems, and risk assessments complex situations can be made manageable. Dekker (2002) captures this fallacy well by arguing that accidents are no longer perceived as uncontrollable events, but rather as failures of risk management, and behind these failures, Dekker argues, there is a person or group who is to be held accountable — even blameworthy. According to this perspective, it is the task of experts to give meaning to these "accidents" and to explain which risk factors were not controlled, when, where, and by whom (Fenton, 2015a, p. 272).

Hope, I believe, is the most powerful positive force in aiding children and young people to recover from prior adversity. Love, reflective of its alignment of usage with hope in the literature search, also holds a place of great significance in our work, yet until recent times the word *love* remained underemployed in the literature. The recent interest is reflected in a special edition of the Scottish Journal of Residential Child Care (Smith, 2016) entitled "Love in Professional Practice".



Source	Risk	Hope	Love	Pain
BJSW	88	9	14	0
CYSR	3600	1291	791	309
ERIC	11072	1352	1171	590
SSA	12747	689	579	729
ESDS	428	99	8	65
CD&AS	8765	416	600	693
Total	36700	3856	3163	2386

Figure 1. Risk. hope, love, and pain literature analysis.

There is a growing body of academic literature addressing the use of these words, with Professor Jim Anglin doing the field a great service by introducing the term "pain-based behaviour" in 2002. However, as the literature search revealed, pain remains overwhelmingly marginalised by the dominance of risk. There may be many reasons for this and for the purposes of this article, I shall advance merely one of the possible reasons, again to suggest potential forces at play. I propose that risk is a seemingly objective construct, emerging into the social care and child and youth care fields from the world of commerce. It is recordable, measurable, and quantifiable, which renders it compatible with quantitative research methodologies and the all-powerful randomised control trials, the so-called "gold standard" of research methodologies. Love and hope are considered entirely subjective concepts unamenable to quantification and measurement, and thus more suited to qualitative research methodologies. Pain, despite its paramount place in medicine, a discipline dominated by quantitative paradigms, remains more aligned with subjectivity than objectivity. It has, to date, eluded efforts to meaningfully and accurately quantify, measure, and record its existence utilising the technological tools of science

and medicine. Instead, self-reporting assessment tools are used, such as the Smiley Face Pain Scale (Tomlinson, Von Baeyer, Stinson, & Sung, 2010), in which a child or young person indicates which face best matches the level of pain they are experiencing. Adults are usually asked to specify a number on a scale of 1 (low pain) to 10 (high pain). Because no objective technique for measuring pain is available, both types of scale remain in common use in medical settings worldwide.

Therefore, from a scientific inquiry stance, risk is well suited to the research task whereas love, hope, and pain are much less so. In an arena where professional status is being sought by social care and child and youth care workers, employing the language of science to further this goal of achieving professional status is more likely to happen. I know I have fallen into this tendency over the years to appear professional, especially to people from other professions. It is good to see the merit of using plain English gain recognition within the health professions[1] to combat this pitfall, which also serves to distance professionals from those they serve.

Pain and risk possess similarities in that they are both most-often perceived in negative terms only. In my view, this is a widespread misunderstanding, and I suggest the analogy of cholesterol to illustrate my position. Cholesterol is commonly seen as a negative health indicator for humans whereby high cholesterol is bad for our hearts and low cholesterol is good for us. Many people ingest cholesterol medications and food supplements in order to manage their cholesterol levels within what are ever-changing parameters of tolerance set by the medical professionals (Nayor & Vason, 2016). However, this is only part of the picture as cholesterol is actually vital for human health: the "good" HDL cholesterol offsets the negative effects of the "bad" LDL cholesterol. Few people appreciate this distinction with regard to cholesterol just as few understand the benefits of pain and risk as opposed to the solely negative effects attributed to them.

This article will consider some of the issues inherent in working with children and young people who have experienced trauma and adversity or are deemed to be "at risk" of experiencing trauma and adversity, and who are therefore being brought into the care system. Topics I will discuss include pain, risk, stress, anxiety, vulnerability, empathy, self-care, magic, confidence and vicarious confidence, and the context of residential care.

Looking Back: My Growth in Understanding Pain

Pain is something that everyone has experienced and thought much about. Initially, earlier in my career and life, my position on pain was that it is a bad thing and to be avoided if at all possible. I did, however, recognise that it serves a vital function in alerting the brain of potential harmful occurrences to the body that require action to manage in order to avoid further harm and possible death. Also, I recognised the importance of pain with regard to motivation and moral development (Fenton, 2016a). Still, it was predominantly a negative and unpleasant experience to

[1] For example, see a press release from Ireland's Health Service Executive, "Plain English Guidelines launched": https://www.hse.ie/eng/services/news/media/pressrel/plain-english-guidelines-launched-communicating-clearly-for-health-professionals.html

be avoided if possible, as who would welcome signs of possible harm or death? But given we all experience pain, this common experience affords a shared language that we can employ to connect with others, especially those currently experiencing pain or exhibiting "pain-based behaviour" (Anglin, 2002). Seen from this perspective, pain presents a valuable opportunity for empathetic responses for workers attempting to connect with hurt children and young people.

> Whilst the ability to forge good interpersonal relationships is desirable, but often not essential for highly developed professions such as medicine and law, it is an absolute precondition of effective social work practice (Chu and Tsui, 2008; Chu et al., 2009; Proctor, 1982; Ward et al., 2010). Before all others, the core skill required by social work is the capacity to relate to others and their problems. (O'Leary, Tsui, & Ruch, 2013, p. 137）

To advance my argument, I will give some background on my thought processes. I recognise that my understanding is constantly evolving and will therefore likely change in the future, so I do not lay claim to any enduring truth. I believe that context is vital to understanding the individual human experience and nowhere more so than in child and youth care work.

Learning to Live "On The Edge"

In 2015 I wrote a book titled *Social Care and Child Welfare in Ireland: Integrating Residential Care, Leaving Care and Aftercare*. One chapter covered my experience as a social care worker working in children's residential care services over a 25-year span. I summarised the chapter:

> So, to bring my chapter to a conclusion, it is appropriate for me to give a brief overview of my experience of working with Keith [name changed] and others over my years of practice in residential care. This experience has taught me that the most appropriate approach is one where tolerance of risk and uncertainty, use of self and collaborative meaning-making are fundamental to practice. This approach I now regard as "care on the edge" — on the edge because often I was unsure of which way events would unfold with the ever-present possibility for things to go either positively or negatively with very fine and shifting lines demarking one from the other. This, at times, induced stress and anxiety on my part, that growing feeling of impending doom in the pit of my stomach, whilst attempting to outwardly portray a façade of calm and confidence. All the while I would be forestalling the rising temptation to act decisively to alleviate the uncertainty, as such action might be motivated by fear and anxiety and could have made things worse. This was not inaction to avoid conflict, rather inaction to avoid an unpredictable reaction. Yet by tolerating the uncertainty and managing the risk things tended to work out well in the end. I have also learned that:

> Each child is unique and so their needs will be best met at unique and shifting locations along these continuums (of care and need) and so we must be prepared to shift along these continuums with them. (Fenton, 2015b)

> Many children in care, especially those in residential care, live "on the edge" — the edge of social and educational exclusion, the system of care within the placement of last resort, the judicial system, crisis and mental ill health, to name but a few. Consequently, the worker moving to the edge with them facilitates closer connection and thereby better understanding of their realities. This can then aid in predicting their responses, individually and as a group, and thereby chart the best course of action. There is also the enhanced potential for co-regulation, though in my experience this can be an exhausting space to inhabit due to the reality of the stress and anxiety these young people must live with for prolonged periods of time. That "feeling of doom" in the pit of my stomach, the foreboding that things were about to go very badly wrong, and the feeling of exhaustion at the end of a tense shift, can be ever-present for these young people for prolonged periods of time. Understanding and appreciating this makes their willingness to try to cope, with varying degrees of success, therefore all the more remarkable.
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> In sharing experiences with other workers it is abundantly clear that the vast majority also have experienced the "on the edge" dynamic in their work. However, these can be turned to advantage with time, reflection, good supervision and support. In my own case, as the years went by the feelings of anxiety reduced as I became more at ease with risk and uncertainty. I like to think I became less uncomfortable and fearful at the edge as I became more certain that this was the right place to be, but I retained the connection to the feelings I had previously experienced. (Fenton, 2015a, pp. 55–57)

So, this was my position in 2015 where I was acknowledging the importance of being able to tolerate distress and anxiety, conditions that may be considered mentally painful or "pain-based", and the experiencing of bodily pain in the psychically-induced stomach ache produced by this uncertainty and worry. I was, I believe, beginning to recognise the ability of the worker to tolerate these painful experiences as being critical to the professional development of seasoned care workers who remain working in residential services over lengthy periods of time whilst retaining their motivation and ability to care with authenticity.

Self-Care, Empathy, and Pain

I also wrote about self-care in this book and following publication of the book further developed some of the writing into a model of self-care titled "Relationship-Based Self-Care in Social Care: The SOS Model" (Fenton, 2016b). Within this model I identify phenomena such as vicarious trauma, secondary traumatic stress disorder, vicarious post-traumatic stress, compassion

fatigue, carer burden, and burnout, and identify that I have experienced most of these conditions in my time working in care. I then identify a second parallel range of positive phenomena that afford potential remedies to the aforementioned negative phenomena, all of which occur in the milieu of children's residential care settings. These are vicarious resilience, compassion satisfaction, self-compassion, and post-traumatic growth. The proposed lesson here is that the daily work itself, undertaken well and with relational authenticity, empathy, and compassion, can play a key role in self-care and the prevention of burnout. However, I also identify a third phenomenon. one that necessitates different responses from the care worker in order to manage their self-care. I term this phenomenon "system trauma". It is the trauma caused to both workers and children by the deficiencies in many current care systems internationally.

> However, systems which facilitate practices such as the expectation of individual accountability without sufficient resources can be seen to be dysfunctional. It is entirely plausible to perceive of such systems as posing a real threat of harm to workers. Here, the risk of what can be termed "system trauma", where the lack of support and resources afforded by the system of care is equally, if not more of a reality for workers than vicarious trauma. Young people are equally exposed to such "system trauma" within a system which, for example, in 2014, had 405 children waiting for an appointment within our Child and Adolescent Mental Health Service (CAMHS) for longer than 12 months (Children's Mental Health Coalition, 2015*).* (Fenton, 2015a, pp. 278–279)

System trauma has consequences far beyond the time within which the individual child or young person is exposed to the "care" afforded them. It is a multiplier of trauma and compounds the trauma these children and young people have already experienced, which necessitated their entry into what for them is a dysfunctional system of care. It also sets the stage for future trauma when the child or young person leaves care unprepared and ill-equipped to survive alone, let alone to thrive. Thus, system trauma affects the whole of a person's life, the past, present and future, and underpins feelings of self-rejection and self-harm and self-sabotaging behaviours.

Within the SOS model training course, I utilise a video clip (TheMedicalEducation, 2013) to demonstrate the importance of avoiding the pitfall of becoming a task-oriented worker in trying to avoid burnout, given that empathic practice requires the sustained experiencing of painful feelings by the worker. This four-minute clip never fails to evoke an emotional reaction in me each time I watch it, despite having watched it dozens of times. It is the segment 90 seconds into the video when Trish, a clinical nurse, talks of removing a barrette from a dead girl's hair in preparation for the parents to see their dead child, and she becomes deeply emotionally affected, with faltering speech, as she recalls the experience. She then talks of how this happened 14 years ago but her ability to retain this feeling of emotional upset and compassion prevents her from becoming a task-oriented professional. She thereby avoids potential burnout, as becoming task-oriented and perceiving people as objects is a known precursor to burnout (Schaufeli, Maslach, & Marek, 1993).

I find this interaction profound as I identify with Trish's emotional reactions to the painful experiences of caring, and I feel connected to her and her medical colleagues in a way I have not previously encountered within the medical professions. We all have shared experiences in caring for others, a language of caring, which includes joy and success alongside pain and failure. (See Zaharieva & Anglin in this issue for a discussion of "the language of pain".)

> The capacity to be in touch with the client's feelings is related to the worker's ability to acknowledge his or her own. Before a worker can understand the power of emotion in the life of the client, it is necessary to discover its importance in the worker's own experience. (Shulman, 1999, p. 156)

So the ability of Trish and her colleagues to tolerate these painful feelings, to remain "on the edge" at any given moment in their practice where they may experience such painful occurrences, is critical to retaining their ability to care authentically and in so doing avoid burnout. It is the same in children's residential care services, and likely in all caring professions, and these feelings of emotional upset we may experience as carers are normal, and do not, as we may privately think, mean we are weak or emotionally fragile. These feelings need to be understood and embraced as positive aspects of the work, and not just as "an occupational hazard, a cost of doing the work" (Courtois & Ford, 2009, p. 205). We must remember that it is all right, at times, to feel broken, as we can recover and possibly grow from the experience if we understand the phenomenon of *post traumatic growth* (Calhoun & Tedeschi, 2013). If we are to connect with and understand the children and young people we support, we will benefit from an empathic understanding of their experiences, knowing what it feels like to them to feel broken by painful experiences.

From my practice experience, I remember that, when I was experiencing extreme stress and anxiety, feelings of isolation and aloneness became prominent. I have come to recognise such feelings as warning signs that I am experiencing stress and need to take remedial self-care action. Understanding that stress can be an occupational hazard, but that it can be utilised positively, greatly enhances a worker's ability to practise self-compassion (Neff, 2011), which can be invaluable to a worker's well-being, especially at difficult times.

A technique I employ to manage my own self-care, and often in supervision of others, is to focus on the following lines that I keep visible on my office wall.

We are each on our own life journey.
I am not the cause of this person's suffering,
nor is it entirely within my power to make it go away,
even though I wish I could.
Moments like this are difficult to bear,
yet I may still try to help if I can.

(Neff & Germer, 2018, p. 142)

Wounded Healers: Connecting with Others Through Our Own Pain

My second book, titled *The Stolen Child: WB Yeats and Carl Jung — Relationship, Belonging and Compassion in Caring for Children in Care*, was also published in 2016. In it I further developed my thinking on the role of pain in social care and child and youth care, employing my experience of the loss of my father as a young boy, two weeks before my 13th birthday, and how this influenced my life and my professional practice, both adversely and positively. I became lost following my father's death, and for many years engaged in self-sabotaging pain-based behaviours, not knowing why. As one of my closest friends (now deceased) said of me years later, I was the ultimate rebel without a cause.

In later years, I came to recognise that I was mostly rebelling against myself for not fitting into this world, which prevented me becoming who I later became and now am. I believe that this is common for children in care, and I can employ my experience of being lost to empathise with these children and young people, in the role of a "wounded healer" as theorised by Carl Jung (1948/1969, p. 116) when he first referenced the phenomenon of "the wounded physician". Being a wounded healer, as Carl Jung and Sigmund Freud themselves were, is not necessarily a deficit in caring professions. For example, Jackson (2001) identifies the wounded healer not as a flawed professional, but rather as one whose past experiences can be utilised to better attune them to caring for others. Awareness of one's prior wounds and their influence in the present is challenging; however, it is critical if we are to leverage the potential of attunement and avoid being reactive or merely task-oriented carers whose actions are fuelled by unconscious forces.

It was only the passage of time and the support of others that enabled me to find a resolution to the experience of the loss of my father. Critically, it was one person, my son, who needed me in a world where I perceived no one else did that enabled me to find my true self (Winnicott, 1960/1987). So, I now can utilise this experience of pain to connect with others experiencing such feelings of hopelessness, alienation, and despair, and to have compassion and understanding, often expressed as tolerance and patience, for their behaviours. After all, these behaviours at times mirror some of my own past behaviours in their irrational and self-sabotaging aspects and I suspect, if we all were to truly look into our past, for many other professionals also. As Carl Jung said, "Knowing your own darkness is the best method for dealing with the darkness of other people" (Jung, 1973, p. 237).

I found that once I began to pull away from these self-defeating behaviours, I had to face the pain that had driven much of these behaviours to avoid re-engaging in them. This meant facing and staying with the pain associated with the loss of my father, a pain I had been avoiding experiencing for many years. This was not a quick process; in fact, to a degree, it remains ongoing to this day. As van der Kolk has said, "Knowing what we feel is the first step to knowing why we feel that way." (2014, pp. 95–96)

Paradoxically, in attempting to help others, the children and young people and their families I encounter in my practice, I have found that I have benefited personally, oftentimes through vicarious processes. I have gained insight into my own experience through supporting others through their experiences, giving validation to the cliché that "it is in helping others that we help ourselves".

Vicarious Confidence: Creating a Holding Relationship[2]

My practice experience has afforded me one of my greatest assets in working with children and young people, teaching me, at a minimum, as much from failure as from success. This learning has, however, not always come easily for me. There is an old saying that sums this up well: "Experience is the hardest kind of teacher, it gives you the test first and the lesson afterwards."

One example of this learning occurred when I was a worker in a children's residential home some years ago. My colleagues and I were attempting to care for three teenage girls who were engaged in a cycle of para-suicidal behaviour, repeatedly ingesting large doses of paracetamol. We spent many shifts in the local hospital with the girls, sitting in uncomfortable chairs throughout the night as they were recurrently admitted following each overdose. They were coming very close to known lethal dosages of paracetamol, and this appeared to be more by chance rather than intentionally on their part, as they appeared unconcerned as to the consequences of the risk they were taking. I had several years' experience in social care at this stage but had never encountered a situation like this, and I was experiencing real anxiety and fear that one of these girls would take one pill too many and come to grave harm or die. Irreversible liver damage was an ever-present possibility.

I now know that it was my anxiety that led me to believe that they needed to be removed from the home, making me believe it was too dangerous to keep them there as we could not prevent them accessing and taking these tablets. I will never forget how anxious I felt, so close to the edge (Fenton, 2015a, p. 56), beyond which is the abyss from which return unscathed is by no means certain. During this period, it required a lot of thought on my part before reporting for duty for each shift with the temptation to ring in sick being very strong. This was not something I was ever prone to doing but during this time I came close to doing so.

During this time, I observed that while my colleagues and I were extremely anxious the manager appeared calm and her demeanour conveyed a sense of control to me in what otherwise felt like a situation that was out of control. I took the confidence I needed to continue working through this period from the manager's apparent confidence. I followed her direction in the belief that she knew what she was doing and that she had confidence that I, and my colleagues, were doing the right things in how we were attempting to care for these girls and keep them alive.

[2] Much of the material in this section has been published on the goodenoughcaring.com website at http://www.goodenoughcaring.com/the-journal/1a-vicarious-confidence/

As most often happens, the crises abated after some weeks as the cycle ended, thankfully without irreversible harm befalling the girls, and a sense of normality gradually returned to the home. Sometime later, when I reflected on this time with the manager in supervision, she told me that this was the worst time of her life and that she too was extremely anxious that someone would die or suffer life-changing consequences. I am forever indebted to her for her honesty and bravery in telling me this as once I realised this was the reality, I was then able to see just how important her façade of confidence was in enabling me, and others, to continue to do our jobs. She internally managed her anxiety and tolerated the uncertainty in the knowledge that, had she not, the girls' placements would most likely have broken down, resulting in their unplanned discharge from the home — an outcome that has been shown to be deleterious to the developmental trajectory of both staff and young people (Ward, 2009; Jones et al., 2011).

The process whereby I took the confidence I needed from her, I have come to recognise, was vicarious confidence in action and since I recognised it for what it is I have always tried to replicate it in my work with children and young people and when in leadership roles. I have also encouraged others to do likewise, and I believe that this experiential learning on my part is a prime example of the merit of imitation, which is linked to role modelling and identified by van der Kolk as "our most fundamental social skill" (2014, p. 112). Just as importantly, I have learnt what not to do through the same processes. Clearly, this is one of the benefits of practice placements in social care and work professional qualification courses.

I also began to see that at the core of social care and work practice is the fundamental necessity to manage our anxiety in caring for traumatised children and young people given how much risk is involved in attempting to care for them, especially during times of crisis. If we do not manage our anxiety, we are prone to making rash decisions motivated by fear, as I was experiencing during this crisis cycle with the teenage girls.

The unconscious forces at play can be illuminated by employing the lens of psychoanalytic theory. Anxiety and defences against it are central to psychoanalytical theories of personality development (Freud, 1926; Klein, 1930). Menzies Lyth (1988), focusing on the nursing profession as we did earlier with Trish and her colleagues, examined the role of anxiety and the defences against this anxiety within institutions, for the individual nurse, and within the profession. She identified a range of defences within the nursing structure in hospitals, including:

- **Splitting up the nurse–patient relationship**: Rotating nurses tasked with carrying out a wide range of functions and tasks prevents them from spending significant amounts of time with the same patient. They may carry out a certain task but not all of the tasks for any one individual patient. This is aimed at diminishing the potential for close relationships forming between patients and nurses and thereby protecting the nurse from experiencing anxiety;

- **Detachment and denial of feelings:** The nurses must learn to control their feelings, refrain from excessive involvement, avoid disturbing identifications, and maintain their

professional independence against manipulation and demands for unprofessional behaviour. I have referenced this previously as the "reification of the fabled state of 'objectivity'" (Fenton, 2016a, p. 21), which conspires to promote detachment in order to minimise attachment;

- **Elimination of decision-making via ritual task performance:** Precise instructions are given to the nurse to perform the array of assigned tasks in a ritual manner, which reduces the need for the nurse to make decisions, as decision-making involves anxiety as to the potential outcome of the decision.

Menzies Lyth, from a psychoanalytical perspective, identified that, "The core of the anxiety situation for the nurse lies in her relation with the patient. The closer and more concentrated this relationship, the more the nurse is likely to experience the impact of anxiety." (Menzies Lyth, 1988, pp. 51–55).

From a psychodynamic perspective, the avoidance of painful feelings for workers provides a further example of the avoidance implicit in the management and risk models and systems currently dominant in social care and child and youth care practice. This defensive and avoidant function can occur when workers divert their attention from the painful feelings invoked by connecting with the child or young person and focus instead on technology, paperwork, and procedures, which can "sometimes be understood as avoidant or displacement activity which enables practitioners to divert their attention from painful situations they are faced with" (Ruch, Turney, & Ward, 2010, p. 38). Additionally, if an adverse event should occur, it can be cast as a systems or treatment failure and not as a failure of any individual worker. Similarly, from a medical model perspective:

> The preservation of life is an organisational imperative that becomes dominant, often irrespective of the quality of life that the patient will have and to the detriment of staff morale whose ability to care and act realistically rather than omnipotently are consequently undermined. Since care is a slow process and does not produce the dramatic results desired, it is denigrated as being ineffective, whereas "cure", which is exciting and offers a defence of omnipotent dential of the chronic nature of the problems being addressed, is idealised. This is also an expression of the professionals' use of "treatment" as a defence against the inevitable experience of helplessness and failure. (Stokes, cited in Obholzer & Roberts, 1994, p. 122)

The question arises as to whether the professions of social care and child and youth care are affected by similar "care" versus "treatment" dynamics and whether some forms of "therapy" or "therapeutic care" are idealised as magical solutions to complex problems. We shall return to the topic of magic further along.

In well-functioning children's residential care homes, attachments and close relationships between workers and children and young people are encouraged (Anglin, 2004). Thus, from the

above-mentioned issues associated with anxiety and relationships, we can see the imperative for frontline workers in caring professions to be supported in their task of forming meaningful relationships with the children and young people in their care, given that this will likely expose them to experiencing elevated levels of anxiety. In my experience, good supervision regularly addresses anxiety as a critical area of self-care and practice.

In concluding the vignette with the manager in the children's home, I came to see that she managed her anxiety better than my colleagues and I did, which meant that the situation was managed as well as such a situation could be.

While working in this same home, I also learnt from a skilled colleague the phrase that "sometimes we have to fake it till we make it", and this rang true with me following the experience with the three girls. I was not feeling confident, anything but, yet by borrowing the manager's confidence I was able to "fake" my own confidence until the crisis abated and my confidence returned. To this insightful quip, I have added that "nothing succeeds like success, and sometimes we have to fake it till we make it and encourage the children and young people to do likewise". This is not merely trust by another name and it is more than belief in a person's potential. It can be argued that trust implies that one believes that someone will do something, but it does not make explicit the expectation of success in these actions, while belief implies an expectation that a person will likely succeed at some future point. Confidence implies an expectation of success in the present, and therefore it must be used judiciously, as expectation beyond a person's ability can be seriously harmful to both children and staff. Good supervision is critical here.

Some further learning about confidence includes the fact that rather than precluding the professional from experiencing vulnerability, confidence is critical in enabling the skilled professional to appropriately utilise and display their vulnerability. The manager I identified earlier clearly demonstrated this in her supervision of me when she showed me her vulnerability by telling me how anxious she had been during this time of crisis. Confidence and vulnerability are not opposites; they coexist, meaning that the willingness to accept and appropriately show one's vulnerability to another is not a sign of weakness, rather, it is a sign of strength and confidence.

Furthermore, displaying vulnerability is not the same as displaying fear. My practice experience has taught me that just as a child or young person's display of vulnerability can evoke vulnerability within me, a worker displaying fear can evoke fearful responses from children and young people. These fear-based responses may include aggression, as young people cannot manage the feelings and memories the fear causes them to (re)experience and they revert to inappropriate and unhealthy learned coping behaviours. Vulnerability, however, poses much less threat to others than fear and thus, I believe, its appropriate employment can be a highly protective factor for social care workers. In all circumstances, however, the display of a façade of confidence is critical.

However, while displaying confidence is critical, this does not mean that one has all the answers or knows what to do in all situations. People are dynamic, and contexts ever-changing,

meaning that new and complex situations arise constantly. We work with human beings and few things in this world are as messy and unpredictable, yet wonderful, as human relationships. Nobody can know what the right thing to do is in all situations no matter how experienced or educated they may be. Confidence also means that we are able to tolerate uncertainty and unknowing, as we are confident that the answers and the best way to proceed will become apparent, leading to favourable outcomes for both the workers and the children and young people in their care. This much experience can teach us.

One of the most powerful phrases I have utilised in my practice is "I don't know, but…". This is said with confidence that I, or they, can find the answer or, better yet, that we can find the answer together. I have learnt that you only get so many chances when building trust with children and young people who have experienced adverse childhood experiences. If you tell them something with certainty that later turns out not to be true, trust will be lost and with this their confidence in the worker. Both will then be hard to regain. Consequently, in instances such as these, "faking it till you make it" is not something I advocate; honesty is paramount.

In my opinion, the ability of the worker to tolerate uncertainty is a true measure of their professional development and skill. When I worked as a direct residential care worker, I learnt to be wary when working with shift colleagues who were prone to certainty. Often, it was on these shifts that avoidable difficulties tended to arise as these workers were not open to alternative meanings to events beyond what their certainty told them, just as my anxiety "told" me the girls should be discharged in the earlier vignette. They tended to rush to conclusions and decisions and I observed that the children and young people recognised them for this trait. Consequently, over time, I became uneasy around people exhibiting a high level of certainty while at the same time I came to recognise the value of curiosity, which induces thinking, in social care. I believe a confident worker is a curious and thinking worker, unafraid to say "I don't know, yet".

There is also the contentious issue of control in residential child care that bears examination. Control, in my opinion, is linked to professionals' ability (or inability) to manage their anxiety and tolerate uncertainty. It is my belief, based on my experience, that control within residential care for adolescents is largely an illusion, and the higher up the management ladder one goes the more illusory it becomes. A more appropriate way of looking at control is "maintaining a sense of control" (Anglin, 2002, p. 176) rather than seeking to be in absolute control. Once we accept this and cease trying to achieve control through coercion or reward, we become liberated to achieve what in fact we are seeking, a healthy environment where children's needs are therapeutically met by staff whose well-being is valued and promoted.

By giving away "control" to both staff and young people through empowering and then motivating them, congruence (Anglin, 2004) is enhanced. People will, given the right resources within the right circumstances, most often choose to do the right thing, and this is true of residential care services too. Thus, by not seeking to control others we are less likely to need to exercise control; this is the great paradox of our current risk management and control hegemonies: by

seeking to control that which we cannot control we actually diminish what we are seeking (Fenton, 2016a, pp. 57–58). In other words, our attempts to make things safe make them riskier and the more risk-averse we are, the more dangerous things become (Blades, 2016).

If we do not meet the needs of adolescents for autonomy and self-determination by empowering them with age- and developmentally-appropriate levels of agency they will either comply with our directives under duress and therefore not internalise the changes we are seeking to teach or impose, or they will reject our authority and through their assertive and non-compliant behaviour take the legitimate sense of agency they seek. If neither of these scenarios unfolds there is the potential for them to seek to have these needs met elsewhere, which can expose them to a host of harms that we, the professionals, can do little to ameliorate, as we have lost their trust and with it any possibility to meaningfully engage with and assist them (Fenton, 2016a).

Embracing Pain

The ability of workers to tolerate uncertainty and the anxiety (pain-based fear) this induces are critical to their efficacy and well-being; their success or failure in managing this will shape their future within the profession and the type of care worker they become. This experiencing of anxiety mirrors the need for those we care for to learn to experience and tolerate deep emotions as being essential for recovery from trauma (van der Kolk, 2014). However, this is no easy challenge as we are vulnerable to the tendency to "prefer the certainty of misery to the misery of uncertainty" (Perry & Szalavitz, 2006, p. 55).

In *The Stolen Child*, while addressing the issue of pain, I made the statement that, while I recognise the existential importance of pain, I take little or no comfort from pain. However, I have thought longer on this statement since the publication of this book and I now recognise that this is not quite accurate. I do, in fact, take some comfort from times of melancholy, prompted by fond memories of departed family or friends. I did acknowledge then that recovery is framed within the ability to experience the full range of emotions, positive and negative, and not merely the elimination of painful feelings, but I did not recognise just how much the experience of painful feelings can actually be a comfort and of benefit.

These painful feelings can counterbalance the highs of life; both are needed if we are to truly experience the full range of feelings and emotions in the human condition and interaction with others. It seems we must embrace the full spectrum of human emotions to be fully functioning human beings (Rogers, 1965). We cannot cherry-pick the good only, as for each high there is a counterbalancing low, and if we seek to avoid the low we must limit the high also, thereby living limited lives within a limited range of human feelings and experiences.

At the same time, I recognise that my ability to sit with painful feelings was not developed whilst I was lost following the death of my father and that it is just such feelings that the children and young people I work with need support to sit with also. As previously identified, it is not a quick or easy journey and may involve lengthy processes wherein two steps forward and one to

three steps back may at times be the reality. It may also be the case that it may be years after we have parted company from these children and young people before they actualise the meaning of the content of the care interactions we had with them. But where there is life there is hope, and there is nothing more important to the lives of children and young people than hope.

These processes are very important to bear in mind with regard to responding to pain-based behaviour, as we know that we tend to avoid the recurrence of pain by avoiding the circumstances that led to the initial painful experience — Pavlov's dogs and behaviourism springing to mind. This desire to avoid pain can, then, lead to behaviours that eschew actions that previously led to, or are associated with, past painful experiences. Thus, inaction by workers can be seen as a less recognised pain-based behaviour if the motivation, whether conscious or subconscious, is the avoidance of pain.

Pain affords us a lens through which to interpret both our own behaviours and responses and those of the children and young people we work with, and a language that captures much of what may be missed by risk perspectives. I do not, however, seek to promote one approach or perspective above another as this is the very flaw I identify with dominant paradigms currently. Rather, I propose that the critically thinking worker must synthesize all the information available to them and make an informed decision by exercising their professional judgement on what best meets the needs of the individual child or young person with whom they are working, in that presenting context. It may well prove to be the case that there are times when we must "go to where the child has suffered the most — therein lies their greatest potential for growth*"* (source unknown).

In reality, pain has a positive role to play in our lives. We cannot, for example, experience love without pain (van der Kolk, 2014), so why would we not take at least some pleasure from pain when it meets positive needs — is this not actually healthy and in our own self-interest?

The Stolen Child includes reference to fairy tales, mythology, and magic, all sources of potential misunderstanding and avoidance. Some people cite the frightening nature of many fairy tales and claim that these can be damaging to children as they may make them fearful of life. However, just as with risk and pain, this is but one dimension of fairy tales and fails to recognise the greatest power of fairy tales — hope — which is not recognised in these discourses. Fairy tales convey hope through the common theme that monsters and dragons exist but that these can be overcome by children (Gaiman, 2016).

There is an argument to support the claim that "magic begat science" (Fenton, 2016a, p. 57) with, for example, chemistry having emerged from the study of alchemy, astronomy from astrology and pharmacology form herbalism. Magic can also be demonstrated to be a real phenomenon in 21st-century social services. Stivers (1999) illuminated a dynamic that emerged in the mid-to-late 20th century whereby the role of technology has assumed "magical" status in organisational and business operations. He convincingly argued, and I have witnessed this many

times in an Irish social services context, that when major failings and failures occur the response of the organisations or agencies is to nominate that they are implementing new "systems" that, it is claimed, will ensure that such failures will not reoccur. This is the magical component that Stivers references, as these technologically based systems are often unproven in the specific context of the organisation and the failures that have occurred. They may have allegedly worked in different countries or contexts, and, key to this strategy, they will require significant time before they can be evaluated following the announcement of their imminent implementation.

Gambrill (2012) further identifies another form of magic in which the brain is fooled by what we see, a favourite technique of stage magicians. She identifies how the authority invested in science and technology creates an allure effect, "which can lull our critical thinking skills into quiescence" (p. 329) by influencing cognition. Gambrill identifies magnetic resonance imaging (MRI) brain scans as a case in point. She argues that MRI images of human brains are so convincing to an audience via their association with a "harder science", such as physics and chemistry, that we unquestioningly place trust and belief in these images and the meaning attributed to them. Furthermore, data presented alongside these images are equally persuasive, apparently benefiting from the "allure of credibility" created by the brain image, and are not subjected to the same rigorous critical evaluation as data would otherwise be subjected to.

I wonder if to these arguments we might add the staggering mathematics involved in neuroscience, which bamboozles us by its magnitude and complexity, thus causing us to accept these claims as truths as we cannot do the necessary thinking to decipher such large numbers. Numbers such as "100 billion nerve cells (and ten supporting glial cells for each of those). Each one of those billions of neurons makes between 5,000 and 10,000 connections, producing extraordinarily complex networks" (Perry & Szalavitz, 2006, p. 120). Perhaps, also, we are seduced by our own grandiosity, the complexity ostensibly making us cognitively far superior to any other living organism or indeed computer, so we accept this as truth as it massages our egos and comforts us in an increasingly uncertain world where, for example, artificial intelligence is an emerging reality with anxiety-evoking potential in the event that it is not harnessed safely. In any event, this psychological tendency for brain images and attendant data to dull critical thinking can be summed up concisely with the quip that "when we see a picture of the human brain, we stop thinking".

Bruce Perry (2016), one of the leading figures in the domain of neuroscience, cautions that neuroscience can only reveal half of the picture of the world of a traumatised child or young person, as it only affords insight into the individual inner reality and not external or environmental and social influences. Perry (personal communication, 23/11/2018) further cautions "we humans are so complex that any single frame of reference or perspective will be incapable of capturing all aspects of the human condition. We should resist any efforts to be overly-simplistic or one dimensional in our attempts to understand these complexities."

Critical thinking is one of our greatest assets in aiding and protecting children and young people as we ourselves are our own greatest asset in undertaking this task, and we must nurture

and protect this skill at all times. As Jim Anglin (personal communication, 28/2/2014) once advised me, "Stay curious and question everything", some of the best professional advice I have ever received.

Though not offered as an incontrovertible truth, there is food for thought in the quip that "the brain is the most important organ in the body, according to the brain".

Conclusion

Pain, and to a lesser extent love and hope, are poorly understood and undervalued within social care and child and youth care work. Perhaps this may be owing to the subjective nature of these concepts, as I have argued in this article, or perhaps it is owing to the historical usage of these words and the imperative for achieving professional status now dominant in the care sector where there is a need to employ the language that demarks the emergent professions of social care and child and youth work from other professions. Perhaps contributing to the validity of the latter proposition is the dominance of the term risk, an objective, techno-rational term, within the sector.

Children are harmed most often within unhealthy relationships with adults and recovery can only occur within healthy relationships with caring adults, which emerge from connections.

We are broken
within the context of relationships;
and we are also healed
within the scope of relationships.

(Hilda Nadjiwan, as quoted by Dorothy Vaandering, 2010, p. 1)

If we are to truly aid children and young people to recover from traumatic experiences then we must understand our own pain and the pain of the child or young person, its origins and meaning, and how this pain influences the behaviours and responses of both them and us. We must also understand the dynamics of the interplay of pain-based behaviours and responses between both parties — the pain that exists both within us and between us.

However, connecting authentically with these children and young people means we must also connect with their pain and this can be painful for us as we experience their pain both vicariously and first hand in the form of anxiety, uncertainty, and emotional upset. We cannot connect only with the unhurt aspect of the person and ignore their pain-based aspect without our relationships with them being diminished. It is deeply painful and distressing to bear witness to a child so hurt that they "bleed pain"[3], as we will undoubtedly do at times over the course of our

[3] I wish to thank Michael Murphy, formerly of the University of Salford, for his input and to acknowledge him as the originator of this term.

careers if we are caring authentically. We must become tolerant of this ever-present possibility of encountering pain and continue to connect to these hurt children and young people. This requires us to become competent in managing uncertainty and anxiety and capable of living "on the edge".

"The price of love is the agony of loss" (Perry & Szalavitz, 2006, p. 90), as I found out early in life with the death of my father, yet I also found out that love offered the pathway to a resolution to this pain through the love for my son. To love is also to care, and clearly, we want and need to continue to care for and build connections with all the children and young people we encounter in our work. Therefore, we must accept that we will continue to experience pain and this is not merely the cost of doing the work but also an asset in informing our work.

In brief, to authentically care for children and young people we must be prepared to "feel the pain and do it anyway."

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