<u>Revised November 2014</u>

<u>HOW DO MEMBERS OF A MULTIDISCIPLINARY TEAM</u>

<u>INVOLVED IN RUNNING A THERAPEUTIC PLAYGROUP</u>

<u>UNDERSTAND THEIR ROLE IN THE WORK?</u>

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<u>Thesis submitted in partial fulfilment of the award of Professional Doctorate in</u>

<u>Child and Adolescent Psychoanalytic Psychotherapy, University of East London</u>

<u>Date of submission</u>

April 2014

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<u>Abstract</u>

The aim of this study is to investigate how a multidisciplinary Therapeutic Playgroup within a Children's Centre functions, and the role of a child psychotherapist working in that setting. The playgroup studied is located in a deprived local urban community with a large population of young children. The founding members of the service recognised that historically there had been a low take up rate of professional services for young children.

When an experienced and long-serving child psychotherapist left the service, the team requested that a child psychotherapist replace her, and I joined the team, while still in my fourth year of training. Reflecting on my own experience, and what I learned about my predecessor's contribution, I became interested in the specific role of a child psychotherapist in this setting.

I investigated how the Therapeutic Playgroup operated, what were the origins and the history of the model, and how this had developed over time. I used a qualitative approach; this included interviewing staff members and recording my observations of their work. I became a participant-observer, continuing my professional work in the service, but with an additional research agenda.

During the data collection, the Children's Centre, and the Therapeutic Playgroup within which it was situated, was confronted with diminishing budgets, redundancies and uncertainty surrounding whether it would remain open. The impact of these changes on the staff group is explored in the study.

Researching how the team had operated during less turbulent times revealed a leadership function in operation. The team consisted of people who were committed and who invested in the 'mission' of the institution. From the data, ideas are formed about a type of emotional 'experience' that a child psychotherapist can provide, which describes a distinctive professional contribution to this work.

Chapter 1
Origins of the project

During my clinical training in Child and Adolescent Psychoanalytic Psychotherapy, I was based primarily in a multi-disciplinary CAMHS (Child and Adolescent Mental Health) team in an inner city borough. Aside from the clinical requirements of the training, I was encouraged to participate as much as possible in the work of the team. This meant working together with clinicians from other disciplines, participating in team meetings, and contributing to an increasing amount of 'outreach' or community based work.

There was a long standing working partnership between the CAMHS team and local Sure Start Children's Centres. This had developed over a period of 10 years and had been led by a Child Psychotherapist, with an interest in working with 'hard to reach' young children and families. This work was increasingly seen by CAMHS clinicians and management, as well as Local Authority services, as an important way of providing early intervention support to families, not only as a way of preventing difficulties in the future, but also as a way of engaging families for whom the prospect of attending a CAMHS clinic could feel too stigmatising and shameful, or who perhaps were not sufficiently motivated to attend a GP appointment in order to be referred.

This work was of particular interest to the child psychotherapists in the team, in part because of the possibility of applying close observation skills, an integral part of the child psychotherapy training, as well as an appreciation of the importance of early relationships in subsequent development.

My Service Supervisor felt it was important that I was involved in this work, as she felt the future of the profession would require a more 'applied' and visible approach, and this would also provide valuable experience as part of my training.

My initial contact with a Children's Centre had involved providing therapeutic observations of specific children about whom the Children's Centre staff had concerns. I fed back aspects of my observations to a monthly team meeting of the Children's Centre staff, with the aim of providing a fresh perspective, or an alternative way of understanding behaviour, which might inform ways of working with families. I found this work interesting and different from my training requirements, which primarily involved patients travelling to the clinic to receive treatment. This work entailed travelling out in to the community, working with staff to identify the 'patient', and then attempting to provide some form of support, indirectly via the Children's Centre staff.

When a senior Child Psychotherapist left the team, I was asked by my Service Supervisor to take over her 'outreach' role. I had significant reservations about taking on this work. One concern centred upon what it would be like replacing a clinician who was both senior and who had worked in the institution for a number of years. I knew this would be a complex task for a clinician still in training. Also, I was mindful of having a fixed term contract, which meant that I would be in this role for a maximum of one year and I was aware of the potential difficulties this might present for a team who had just lost a valued member. Despite my reservations, I felt that this was an interesting opportunity to learn more about the role of the Child Psychotherapist in a community setting and I had also found the therapeutic observation work rewarding. The Children's Centre I would join had a specific morning Therapeutic Playgroup to which my predecessor had been contributing, which was run in collaboration with members of staff at the Children's Centre, alongside professionals from the Local Authority and the NHS.

I understood that the Children's Centre team had requested my colleague's replacement be specifically a Child Psychotherapist, as opposed to a CAMHS clinician, or another specific clinical discipline. This made me question whether this was because such a successful working partnership had been nurtured with my colleague, which meant the team wanted to replace her with someone like-

minded and trained; or alternatively, was this one way of not acknowledging the loss of such a valued clinician. I thought that there might have been other reasons too, and I was interested in what the team had found particularly valuable about having a child psychotherapist as part of the team, and how, as a multi-agency and multidisciplinary team, they made use of child psychotherapy.

During the first few months in this role I was struck by a number of different issues. It was a shocking change from working in a clinic. Part of the work involved finding a way of communicating with parents and children in an informal, group setting. Finding a space, to talk and to think, within this busy and frequently noisy environment was often a difficult task. I found myself feeling de-skilled without the structure of the setting I was used to working in. The 'drop in' nature of the group meant that families often also 'dropped out', which meant that it was important to develop relationships with Children's Centre staff in order to maintain continuity through phone calls and home visits, engaging with families and encouraging them to return to the playgroup.

When I began my placement, I had no plan that this would provide the location and topic for my research thesis for the Professional Doctorate in Child Psychotherapy which trainees are encouraged to undertake at the conclusion of their clinical training. Although I intended to undertake doctoral research, it was only as the Therapeutic Playgroup in the Children's Centre and the role of a child psychotherapist proved so interesting that I decided that this would provide an appropriate topic for it.   It was four months into my thirteen month placement that I wrote a research proposal, with the encouragement of my service supervisor located in CAMHS, and took on role of researcher, in addition to my professional practice in the Centre. The fact that my research project only became defined in the early months of my placement, and not prior to its commencement, made for some uncertainties in clarifying my field of

investigation, and the kinds of data I needed to carry it out. These issues are discussed in a later chapter on Methodology.[1]

During my time in post, I had limited contact with the wider institution, such as the community art centre, nor did I have contact with the GP surgery, other than liaising about referrals. The institution was a larger project than the Therapeutic Playgroup, and indeed than the Children's Centre that hosted the playgroup, however the study I conducted did not extend beyond the playgroup. My time was limited to a once per week contact with the playgroup and the staff involved with it.

Timeline

August 2011- arrival in post

November 2011- research proposal submitted

December 2011- redundancies discussed in team meeting and possible Children's Centre closure becomes item on the meeting agenda

January 2012- data collection begins

February 2012- staff begin the process of reapplying for their jobs

April 2012- staff told that the Children's Centre will remain open

July 2012- data collection ends

September 2012- my fixed term contract ends

The broader institution

I will begin by describing the inner city borough in which the Children's Centre is located, and to whose perceived needs it was a response. This is an ethnically diverse borough, with almost 80 languages spoken by its school age children, 55% of whom are Bangladeshi in origin, with 50% of households speaking Bangladeshi and Sylheti as the main language at home (Kamaldeep Bhui et al: 2005). The majority of the residents in the borough are of white ethnicity, with a

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[1] Throughout the research I refer to the Therapeutic Playgroup staff group and

large community (22.1%). Somalis represent the second largest minority ethnic group. There are also a number of Chinese, Vietnamese, Indian, Pakistani, and Black African/Caribbean residents. (Neighbourhood Statistics, 2010).

In a paper by Bose (2002), it was stated that the borough ranks as one of the most deprived boroughs in Britain. In 2002 it had an unemployment rate of 15.8%, which compares with 6.5% nationally, and 61% of households reported having an average income of below £9,000 per year. Thirteen per cent of households were also recorded as being 'overcrowded'.

The borough has one of the highest rates of child poverty in the country; in 2010, 57 per cent of children were living in poverty, as defined by the Campaign to End Child Poverty in their review covering England. (Child Poverty Map, 2011).

In the context of the aims of Sure Start, the borough was one of the most challenging, requiring early intervention support, which was provided by being part of the first 'wave' of Children's Centres.

The Therapeutic Playgroup was established in response to the restricted use of professional services for children by vulnerable families. It was thought that if the setting was welcoming and the staff provided a bridge between the professional services and families, important work could be done, to support young children's development.

The institution within which the Therapeutic Playgroup was situated, was a Healthy Living Centre, established in 1984 by the newly appointed Minister of the local United Reformed Church. It was felt that if the church was to survive it needed to adapt and to adopt a new approach. Local artists were involved, as were local people who set up ecological and health initiatives. The church started a nursery, thus helping to meet a need for childcare in the local area. This set the pattern for the development of the Healthy Living Centre: which was responsive to the needs of the community and to the use of the buildings and

facilities in a range of ways and for different purposes. The church was used for all sorts of events, ranging from the traditional festivals to contemporary art exhibitions.

The institution has developed as a secular organisation and it became a registered charity in 1994. The aim of the institution was to engage with a diverse community, which has a young population. The institution was set up to respond and adapt to what the community felt it needed.

> We believe that only through understanding the complex and interrelated nature of these and supporting their development, can effective change be achieved. To do this we deliver services and support across the locality in conjunction with a wide variety of partners. This creates a responsive network of institutions and teams that support individual's needs, their development and community regeneration. (Source not attributed for anonymity purposes)

The community presented challenges in terms of the levels of disadvantage and the extent of poverty. One unique aspect of the Healthy Living Centre was the way that it involved local people in the development and delivery of services:

> The manner in which services are developed and delivered is critically important if they are to achieve the intention of developing community capacity and empowerment. (Source not attributed)

The Healthy Living Centre delivers a broad range of services to over 3,000 people each year including:

- Public health programmes
- Social care programmes
- Adult mental health projects
- Social welfare and legal advice and financial capability
- Skills and employment
- Social enterprises and social enterprise start-up programmes

The Children's Centre which is the subject of my research became a registered charity in 1994. It then expanded rapidly, incorporating a park, and a

Community Art centre. In 1997 a Healthy Living Centre opened, including a GP surgery and Children's Centre. The Big Lottery Fund described the concept as being a successful example of social enterprise.

> It helped to define social enterprise before the term was in widespread use; it created an exemplar Healthy Living Centre; it pioneered an outreach model that brought local people out of isolation. (Big Lottery Fund Research Issue 19, 2005)

The Healthy Living Centre has been described by Chamberlayne and Rupp (2007), as a project which pioneered 'social entrepreneurship', defined as innovative action at "the community level, and a newly creative relationship between the business and social sectors." The authors' report highlights the role of the "exceptional individual" with "outstanding histories" (p.1) in describing the leading figures involved in developing the work and the innovative ways in which they managed to develop the project.

> Such brain-storming sessions or 'cluster meetings' are typical of the organisational structures, which develop around particular projects and avoid formal hierarchies, while designating responsibility. (Chamberlayne & Rupp, 2007, p.8)

In 2011 the Centre had a turnover of more than £4m a year and in excess of 100 staff. It is the third largest provider of adult education in the Borough. In 2011, the Children's Centre had over 1000 children linked to the organisation (source not attributed because of anonymity)

- Approximately 3,000 different individuals attend the centre regularly.
- A third of local households have one or more members who take part in regular activities at the centre, as users or volunteers.
- Thirty-five per cent of local households have had some form of direct contact with the centre over the past year.
- Eighty-six per cent of The Centre's staff live within three miles of The Centre.

- The ethnic breakdown of The Centre's users, volunteers, staff and members closely matches that of the local population.

What is a Sure Start Children's Centre?

Sure Start is a Government initiative aimed at providing families with improved access to childcare, early education, health and family support, with an emphasis on outreach and community development. The programme was originally intended to support families from pregnancy until the children were four years old. Launched in 1998, Sure Start shares similarities with the 'Head Start' programme, based in the United States, and with the 'Head Start' programme in Australia, (National Head Start Association, 2010).

Sure Start formed part of the newly elected 1997 Labour Government's strategy to reduce child poverty in the UK. The initial districts for Sure Start development were selected according to the levels of deprivation recorded within defined areas, focusing on the particularly disadvantaged. However, the Centres were open to all families living in the local area.

Sure Start was initially overseen by the Department for Children, Schools and Families and by the Department for Work and Pensions. Each project was intended to develop independently and to be based upon the expressed wishes of parents and the guidance of various organizational bodies managing each project. Policy on all matters, including choosing volunteers and even the services offered, was determined at a local level.

The gap in services identified in 1998 by the Department for Children, Schools and Families centred upon early years and school provision and in engaging 'hard to reach' families who were perceived as unlikely to attend statutory clinics for services. Children under the age of 5 were identified as being a particularly vulnerable group, with a variety of emotional and behavioural needs remaining unmet due to "gaps in service provision" (Ahmed & Messent, 2000, p.7). Sure Start local programmes opened in 'waves'; Round 1 indicated the first wave of

programmes, which started in 1999. Round 6 represented the final wave of Sure Start local programmes, mostly starting in 2003.

Since 2006 a change was made from Sure Start local programmes to Sure Start Children Centres, which would be controlled by local authorities. Local authorities are also responsible for setting up management structures for their Children's Centres, which may be managed directly by a local authority or by a private or voluntary sector organization. Some Centres on school sites are managed by the school governing body.

The aims and objectives of Sure Start Children's Centres are, according to the literature provided by the Department for Children, Schools and Families, to "bring all the different support agencies together to offer a range of services to meet you and your child's needs, all in one place." (2008, p.1)

> They're somewhere your child can make friends and learn as they play. You can get professional advice on health and family matters, learn about training and job opportunities or just socialise with other people. (2008, p.2)

The objectives of the programme remain broadly popular, but the way in which the programme has developed, together with the evidence of outcomes, have proved to be divisive and controversial.

Lucy Ward (2007), The Guardian Social Affairs Correspondent reported that a 2 year study, led by Gary Craig, Professor of Social Justice at the University of Hull titled, "Sure Start and Black and Minority Ethnic Children", formed part of a government evaluation. The evaluation described Sure Start as a "very serious policy failure" and a "substantial wasted opportunity for deprived black and ethnic minority families". It suggested "serious failings" could be identified in the way local Sure Start programmes work with minority groups.

In recent years, the changes to Children's Centre funding has produced uncertainty and "closure threat" (Richardson, 2011), to a number of Centres

across the country. In 2005, <u>The Guardian</u> journalist, Polly Toynbee wrote, "In any clash over priorities, the under-fives are always sacrificed first".

The 2011 government commissioned report, written by the Labour MP, Graham Allen, called: "Early intervention: Smart Investment, Massive Savings", used Perry's (2002), neurological evidence of the effect neglect has on the development of the brain to illustrate the importance of early relationships, focusing on the social and emotional development of young children from birth. He calls for support for parents from a national parenting scheme. He argues that it is important for services to intervene in the early years, rather than later, when the brain is formed for life. He wrote that all parents need to know how to:

> …recognise and respond to a baby's cues, attune with infants and stimulate them from the very start, and how to foster empathy. (Allen, 2011)

The function of Children's Centres as a place where different services can work with families who need support remains a national aim. It is how and by whom these aims are achieved that remains a politically contentious issue. There are also the disputed measurements and evaluations of success which require further investigation.

Anning et al (2007) conducted a study investigating the variations in the way programmes were delivered in 16 Children's Centres, as well as evaluating the proficiency and the impact of these programmes. The study attempts to understand what worked from both an operational and strategic level. One finding was the importance of staff commitment to finding new ways of working:

> Sustaining this commitment was dependent on strong leadership with a clear vision of the long-term benefits of joint working. In proficient programmes […] Managers had a clear understanding of the conflicts likely to arise from the clash of cultures, beliefs and ways of working of distinct agencies. (2007, p.4)

Another significant finding was the importance of recruiting staff with suitable "personal attributes", (2007, p.1) which links to the significance of personal commitment to the aims of the work, but also suggests that there are certain

people who may be more suited to this work than others. Overall, the study concluded that the engagement with black and ethnic minority families was limited owing to "lack of interpreters and unease about professionals' capacity to respect their cultural preferences and faith requirements." (2007, p.6) Other minority groups expressed a fear of going somewhere new and meeting new people. These were issues that the institution sought to actively overcome.

The Therapeutic Playgroup and its setting

I am now going to describe the physical setting of the Children's Centre, within which the Therapeutic Play Group has its space, a dedicated and specially equipped room. The Children's Centre building is modern and has a distinctive patterned brickwork. It is surrounded by a large green park with a children's playground within it. The Healthy Living Centre appears distinct from the rest of the building because it is curved and is red-brick. Once inside the building, one is met with a large reception and waiting area. The impression it makes is impressive, both in terms of scale, design and light. There are thick wooden beams scattered throughout the area, from the terracotta tiled flooring up in to the high wooden beamed ceiling. A number of corridors lead off the reception area, and there are a number of striking photo canvases, of children and staff, hung on the corridor walls. The Therapeutic Playgroup room is close to the entrance of the building and has large windows that look out into a courtyard. In summer months, the doors are opened and children can play outside. Outside of the Monday Therapeutic Playgroup, the room is used for daily stay and play sessions, baby clinic and for baby massage sessions.

The maximum number of families allowed in any one Therapeutic Playgroup was 15. There was usually one parent with one child under the age of 4, but mothers or fathers frequently brought a second, younger child to the group. The majority of the two and a half hour playgroup time was 'free play', which in practice meant that a number of activities were available, such as painting, sand play, and water play. Children and parents had a choice about how to spend the time.

The room is large and brightly painted with an art and paints section, a soft play area with cushions and mats, a dolls house and kitchen area for imaginary play, and a wide selection of toys spread out in baskets and in cupboards. Large coloured photos of children are mounted on the walls. A child's toilet and sink are situated in one corner of the room. The final forty minutes of the playgroup were structured, a seated snack time followed by a group activity; 'circle time' functioned as a way of concluding the group with singing and games. This was led by a member of Children's Centre staff and encouraged parents, children and staff to all join in together.

The playgroup ran on a Monday, from 10:00- 12:30pm during term time. The team meeting began shortly after the end of the playgroup and continued until 1:30pm. It was held in the adjacent office space. Three separate rooms were attached to the Children's Centre part of the building. Two of these were offices, shared by the Family Support Team and the Children's Centre manager. The third room was an average sized room and a bookable space, appropriate for therapeutic consultations with families. I often used the room for when I felt it would be helpful to meet either with a parent or with a parent and child outside of the playgroup. This room felt sufficiently separate to the large play room, although one was able to hear the sounds of children and parents from within this space.

Staff involved in running the Therapeutic Playgroup

There were a number of funding sources, being The National Lottery to start with, followed by The Local Authority and The Primary Care Trust. The Family Support Team based within the Children's Centre experienced a restructure at about the same time as the data collection for this study. This restructure was intended to create closer ties to the Local Authority as well as creating different staff structures, including new levels of management within the Family Support Team. Within the Family Support Team there were the following members of staff: a Children's Centre Manager, a Family Support Lead, a Play and Learning

Co-ordinator and 4 Family Support Workers. This staff group are entirely based in the Children's Centre. Not all of the Family Support Workers attended the playgroup every week, but at least two Family Support Workers did attend on a weekly basis.

Part of the function of the Family Support Team was to identify families suitable for a referral to the playgroup, as well as deciding on whether a specific professional intervention was suitable for the family; for example, a referral to an Educational Psychologist.

The procedure was that either a GP, or a Health Visitor would refer the family to the Family Support Team, and a home visit would be undertaken by a member of the Family Support Team. Only one member of the professional staff group carries out home visits, and this takes place after the initial contact has been made. Therefore, in a map of the organisation, the Family Support Team would present on the front line of the service.

In order to make a distinction between the members of the team who were not members of the Family Support Team, I have made a distinction between the Family Support Team and the Professional Staff. The professional staff consisted of: an Educational Psychologist, a Speech and Language Therapist, an Adult Psychologist, two Health Visitors and a Child Psychotherapist. The Professional Staff Group is employed either by the NHS Trust or the Local Authority. Staff members are primarily based outside of the Children's Centre, some within a range of settings, others occupying just one setting. Some have managerial experience, or hold managerial posts outside of their playgroup work. However they all work with clients in a formal clinical setting outside of the playgroup, apart from one member of the Professional Staff group. In addition to being regular contributors to the Monday Therapeutic Playgroup, the Adult Psychologist and the Health Visitors worked in the Children's Centre, holding clinics, at different times in the week to the Therapeutic Playgroup.

A referral to the Therapeutic Playgroup could begin with a conversation between two members of staff; a Family Support Worker might suggest that a

particular family would benefit from attending the playgroup because of what they have observed during a home visit. A suggestion could be made to a particular professional staff member, by a Family Support Worker, to introduce oneself to a particular family, for example: "This mother has said that her 3 year old has been lashing out at his baby brother, perhaps you could have a word today?" These kinds of referrals might be thought of as 'corridor referrals', conversations that take place in an informal way, that present the professional staff member with the dilemma of how to proceed, neither rushing in, nor gathering information for so long that the opportunity to engage the family is lost. Alternatively, a more formal route of referral, via a GP, was another way that families could access the playgroup.

Beginning to speak to families in this setting requires a different approach to work in the clinic, and yet I was advised by my colleagues in CAMHS that it was crucial to maintain a 'psychoanalytic attitude,' so I began to think about what this meant in practice.

I was often caught off guard by families and staff when I was asked, in this new setting questions such as, "do you have children?" It was as though the professional boundaries, which usually operate as a buffer for questions such as these were now less apparent. Issues such as helping parents with buggies, clearing up plates after snack time, singing songs during circle time were all part of this work and required some careful thought after three years of learning about the importance of the clinical setting and the transference. It was possible to feel aloof and detached if one did not get adequately involved in the overall experience of the playgroup. At the same time, I found myself wondering if I was managing to hold on to what I thought a child psychotherapist ought to be doing or saying in various situations.

The team meeting
After the playgroup there was a weekly team meeting. This hour long meeting was an opportunity to think about the group, the families who had attended, and

the families who had not. One of the functions of the meeting was to think about whether a family might benefit from a home visit or may need a referral to a specialist service, such as CAMHS, or sometimes Social Care. An agenda of families was prepared at the start of the meeting, this was contributed to by all members of the team. A written list was prepared. I chaired the meeting because this had been the role of my predecessor. All of the staff group were invited to attend this meeting. The attendance varied from week to week, in some weeks 10 people attended, and in other weeks 5 or 6 people. The staff who seemed to attend less frequently were the members of the team who had home visiting responsibilities, and often cited carrying out a home visit as a reason they were unable to attend the meeting. After a period of poorly attended meetings, I would informally approach members of the team and encourage them to attend. This was usually effective and staff tended to agree to prioritise the meeting and were apologetic for their lack of attendance. The ebb and flow of the weekly attendance rates contrasted with some constant features of the meeting; a volunteer from the local community cooked a shared meal for the meeting, and staff ate together while cases were discussed. The meal was appreciated and frequently commented upon as distinguishing this meeting as 'superior' from others. At the end of the meeting all staff joined in to clear up and clean crockery and cutlery. Most professional staff members attended at least fortnightly, in a predictable pattern, and the Children's Centre Manager and Head of Family Support attended weekly. The meeting always started and ended at the same time.

At first I found the facilitator of the meeting role very demanding because it was much more than assembling an agenda and ensuring it was effectively covered. I found that at times it was necessary to encourage team members to attend the meeting by advocating its function as well as encouraging them to discuss aspects of their work. Another of my roles was to formulate an understanding of some of the more complex or challenging interactions that may have taken place during the playgroup and to discuss with team members what might be encouraged and supported in future playgroups with families. Strong, and often,

critical feelings about parents and children were aired during the meeting. There were often opposing views linked to professional ideologies and personal opinions and different identifications formed. I quickly began to feel that part of this role was to help staff to feel safe enough to express divergent and sometimes personal thoughts and observations, but to maintain a boundary around the work that didn't leave staff feeling exposed.

Observational Material from one of the team meetings:

In attendance: Myself, Head of Family Support (FS), Children's Centre Manager (CCM), Family Support Workers (FSW1 and FSW2), Educational Psychologist (EP), Counselling Psychologist (CP).

> At the top of the agenda was a three year old called P, a recent referral to the playgroup from a Health Visitor. EP highlighted that P's mother was reluctant to engage with P in the playgroup, she "sat down and didn't play with him, initially speaking to two other parents". FS acknowledged that this had happened and said she had spoken to the group of parents about how the playgroup was an opportunity to play with the children, not to talk to each other, and then the other two parents had become more involved with their children, while P's mother remained distant from him and began to use her mobile phone. FSW 2 commented that P was 'playing very well independently' and did go to her for help with putting an apron on, although there was a point when he wanted help with his trousers being done up and Mother was on the phone and had asked FSW 1 to help him. I spoke about my contact with P and Mother, I had encouraged her to sit with P and support him during snack time and he had seemed pleased that she was sat next to him. Comments were made about what had happened during song time, at the end of the group. P had become unsettled and had started to run around the room and ignored staff requests to join in with the group. The comments made about Mother became increasingly angry and critical, and then it was suggested by CCM that she might be distracted or preoccupied for some reason. CP suggested that she might not yet know what is and isn't expected of her in the context of the playgroup. I said that I had observed that after a period of not having her attention, when P did have her full attention he became more challenging or attention seeking, as opposed to when she was disengaged and he was getting on with things on his own. I wondered whether others observed differently? FS said she thought he was desperate for her full attention and enjoyed it even when she was cross with him. She went on to say that she felt annoyed with P's Mother, for just sitting on her phone. There are signs on the wall saying 'no phones are allowed'. Perhaps the whole team needed to be clearer that this wasn't acceptable and it wasn't fair on P. I felt that the group had become very identified with P and the way in which something

about him had been ignored. I wondered (to myself) about how this feeling might manifest in the team in terms of how valued or undervalued the work can be at times, perhaps by the 'parents' of the playgroup, senior people who had now left, or absent commissioners and senior managers.

My involvement in this work coincided with a period of funding uncertainty and a number of voluntary redundancies. When I arrived in post, the Therapeutic Playgroup staff group was in a state of emerging crisis. Two highly valued members of the professional staff group had recently left the team and one highly influential member had retired a couple of years previously. There was evidence of staff confusion about why this had happened and what it meant for the remaining staff group. There were worries about completing new administrative procedures alongside thoughts about specific families who had 'dropped out' since the loss of the two staff members. One question that was of particular concern to remaining staff was 'had staff begun to disappear along with vulnerable families? Or vice versa?' Soon after my arrival, the word 'cuts' became part of the institution's vocabulary. This led to a loss of institutional vision and increasing staff disillusionment within the organisation. At times, team members directly expressed their feelings of anger and anxiety at our meetings. I was often left feeling overwhelmed by the effect this had on my capacity as chair of the meeting.

Although the meetings were not an opportunity for a work discussion group, the relationships between members of the team were becoming increasingly strained and required thinking about on my part. Shortly after starting this work, I began to write notes after the meetings, initially as a way of gathering my thoughts about what might be happening and what I might be missing. I began to collect data formally when I had been in post for approximately 6 months. At this point I began to write detailed observational process notes on a fortnightly basis for the next 4 months. In some ways this was an extension of how I was already working, since as a child psychotherapist in training I was expected to reflect on my work.

My experience of facilitating the meetings and working alongside the staff group during my first three months in post produced my initial interest in the specific contribution of the child psychotherapist in the organisation. In order to be able to research the role of the child psychotherapist in this setting, it became apparent that it was necessary to 'map' the staff structure and institutional tasks and to establish to what extent these were or were not being met.

To both carry out the research and to fulfil the role of the child psychotherapist, it was important to understand the way in which the different members of the team approached their work with families. During the team meeting, I was struck by the differences and the similarities between staff members ways of working, with evidence of "internal authority" (Rustin, 2008, p.12), supporting some members of staff. Other staff members appeared to rely less on their training and more on their years of experience as scaffolding their professional identity. In this context, professional identity presented itself as a complex interplay of personal interests and enthusiasm, alongside training and experience that had developed and been adapted to the context of the playgroup.

The study aimed to understand and document, the following central issues:
- the distinctive nature and value of this form of therapeutic play group
- the particular contribution which a Child Psychotherapist can make in this setting (with all its difficulties)
- the impact of cuts and contraction on an innovative institution

The changing role of the child psychotherapist

My initial key concern was to gain a clearer understanding of the role of the Child Psychotherapist in this specific context. One of the aims of the research was to contribute to the developing models of outreach, or community based work that Child Psychotherapists are increasingly involved with. If the complexity of the role of the Child Psychotherapist in this applied work can be better understood then this may make the work more approachable.

It is increasingly the newly qualified child psychotherapists who are being recruited to outreach posts. They often meet the most disturbed or challenging families who present in outreach settings, because of the way in which some acknowledgement of a difficulty is required before a referral to a CAMHS clinic will be accepted or requested. In my opinion, the meeting of some of the most challenging families with newly qualified professionals means that it is important to think about what the demands of the professional role involve and how these demands might be met.

Providing time limited or brief psychotherapy, working with parents and providing consultation for professional colleagues are important aspects of the work of Child Psychotherapists within clinical settings. The majority of my peers have chosen to research single case studies for their doctoral studies. My decision to research professional identity and outreach work is a response to the changing expectations of a Child Psychotherapist working in the Public and Voluntary Sector.

In recent years there has been an increase in posts for Child Psychotherapists or CAMHS Psychological Therapists to work in different settings. There has also been an increase in the number of posts advertised as Mental Health Professionals, Psychological Therapists and CAMHS Clinicians. Child Psychotherapists compete for these jobs alongside Family Therapists, Clinical Psychologists and other Mental Health trained professionals.

My research is in part an attempt to clarify how a Child Psychotherapist might differ or 'cross over' with other professionals, in terms of what they offer in this type of work or role in settings outside of the clinic. In addition to exploring the work within a Therapeutic Playgroup, it will have relevance to other outreach work taking place in schools, GP practices, Youth Offending Services and hospitals, all of which are increasingly recruiting for CAMHS or Mental Health Specialist staff.

In the next chapter I review a range of literature relevant to my study.

In Chapter 3 I discuss the research design and the methods used, as well as the process of conducting the research. Particular attention is given to the use of observation and counter-transference. Chapter 4 is concerned with the findings of the study. I discuss the primary tasks of the Therapeutic Playgroup and whether these were met, as well as exploring the impact of change and uncertainty. I also explore the way in which the staff group understood their specific contribution to the work and the role of the child psychotherapist.

Finally, the conclusion considers the outcomes of the study, including the role of the child psychotherapist in this type of work. I discuss possible areas of future research which may lead to future studies into community based or outreach work.

Chapter 2

Literature review and theory

Introduction to the aims and coverage of the literature review

The literature chosen for this review aims to cover a number of different areas which are linked to the research, including different psychoanalytic approaches to understanding institutional life, contemporary research into multidisciplinary team working and open systems theory. This chapter also identifies a number of different theoretical concepts that are relevant to the study. Mason (1996, pp.79-80) writes "all key research decisions have both theoretical grounds and theoretical consequences" (Ibid., p79). I have drawn upon key concepts and core ideas throughout the research. According to Mason's model of how theory is used in research, the use of theory in this research broadly developed from or through data generation and analysis. However, certain theories were key to the research from the outset, meaning that the task was also to measure my data against these.

Child psychotherapy outreach work is a relatively recent development in clinical practice; however, a number of pioneering initiatives have taken place in the last fifteen years, and these are considered within the context of the research. I also explore theory surrounding professional roles and identity.

Child Psychotherapy in an outreach context

Traditionally, the work of a Child Psychotherapist takes place in a clinical setting. The family is referred to the clinic by a GP, or an agency such as Social Care, or education, and treatment is provided within the clinic following on from an assessment and usually with parallel parent work sessions. The work can be conducted on a weekly or more intensive basis than this. Alternatively, Child Psychotherapists can work with the entire family and provide separate time limited work for children and adolescents and parents.

Particular importance is attached to the setting in the work of the Child Psychotherapist because it provides the skeleton of the work crucial to the establishment of the possibility of working within the transference relationship between therapist and patient. Consistency and predictability of sessions and the setting are vital to this process.

In recent years there has been increasing pressure to meet the demands of a changing NHS that aims to be easier to access and available to more people. This has meant that Child Psychotherapists have tried to find ways of working in a more applied way, for example, by providing supervision and consultation, and also in working in different settings and adapting the model, while remaining psychoanalytically attuned.

Cathy Urwin (2003) has described her role in developing a pilot infant mental health service in an inner city community. Writing as a Child Psychotherapist with a specialist interest in working with young children and parents, she highlights the "assumptions" associated with this specific type of psychotherapeutic work as "the developmental issues faced by babies and small children", which can result in challenges to parents' own experiences of parenting, "reawakening unresolved developmental issues and half-buried or forgotten traumatic experiences."(p. 376)

Urwin cites the combination of the importance of early intervention and the development of infant and young child mental health services which might "reach the hard to reach and, arguably, the most in need sectors of our referral communities" as the motivation for Child Psychotherapists and the members of allied professions who are concerned with what Sure Start can achieve. She further describes the need for a "belief in the overall aims of Sure Start" (2003, p. 376), as well as an interest in outreach, community work. She sees this as an essential prerequisite for becoming involved in the work. This supports the findings of Anning et al (2007), who at that time drew attention to the time limited nature of funding for Sure Start, with the implication that there was an

ending in mind even at the very start of the work.

Urwin's work highlights the aims of collaborative work between Child and Adolescent Mental health services and Sure Start, in order to create an easily accessible service that is friendly and responsive to the needs of the population. She envisaged referrals to other services and liaison with other professionals and Sure Start workers in the management of more complex cases.

In an attempt to identify the specific contribution of the Child Psychotherapist to this type of work, Urwin writes that it is:

> …the emphasis on the process of thinking about the emotional life of the child mobilizing the development of phantasy as it reveals itself in the play and interaction within a transference situation. This may apply to the child, to the parent or to both. It is attention to these processes that informs the therapist about what to ask, and when, about the parents' own childhood, to facilitate freeing a hitch in the parent – child relationship, for example. The latter often results from the intensity of parents' projections of their own unresolved material onto the child. (2003, p.383)

She further notes the challenges of the work with respect to the setting, in particular the difficulty experienced when parents miss appointments, and "there is no obvious agency to whom one might relay information" (Ibid, p.384). She also emphasises the importance of discussion with other members of staff, as well as the methods of communication being subject to revision and updating. The model of work in this research is not an appointment based system, such as the one Urwin describes, but is a 'drop in' group setting in which specific families have been encouraged to attend by health visitors and family support workers. Despite the differences, the difficulties surrounding problematic attendees are also present in this context.

On a personal level, Urwin describes her aims in this work as providing a model for families who may later require professional help. She cites a steady increase in referrals from a range of sources suggesting that, although in its infancy, the work has succeeded in the aim of engaging members of the local community.

This client base differs slightly from that of CAMHS. The CAMHS team where Urwin was primarily based and she highlights that it was an essential "secure base" for thinking and feeling a sense of professional belonging, without which outreach work would not be possible. (2003, p.391)

Urwin's clinical vignettes demonstrate the way in which she applies close observation combined with an understanding and interpretation of the transference to affect change in relationships between parents and children. In addition to this, she describes her adapted technique, which allows for phone calls to families and directive advice. It is in this way that she acknowledges the need to adapt her role within a clinical setting which was necessary for this more flexible way of working to be effective.

Urwin's work is important in the context of this study because her account is the first documented example of a Child Psychotherapist playing an integral role within a Children's Centre and she captures both the enthusiasm and commitment to the project, as well as the difficulties and adaptation required to build a role in this context.

In a school setting, as opposed to a Children's Centre, Child Psychotherapist Emil Jackson (2002) writes about one aspect of work within a 'Mental Health in Schools Outreach project'. This is a project that was established in 1998 in an inner city borough. The motivation behind the project was to find new and creative ways of engaging young people who were considered to be at risk of emotional breakdown. Providing staff with work discussion groups was one of the key areas of work identified in the project. The project was established in close liaison with school staff, and a "consensus was reached that our primary task was to create a space outside the heat of the classroom setting, to reflect on their work." (p.129)

The sense of being available to provide school staff with both what was wanted and what was felt to be lacking appears to have been particularly important in establishing the project within the school setting. He carefully considers the

importance of clarity surrounding practicalities, such as the significance of the setting and the importance of being open about the aims of the work discussion.

The paper illustrates the success of the project with a second school project just about to begin. At the time of writing the paper, the work had been in progress for three years, which suggests the length of time required for such work to take form. Jackson describes one of the outcomes of this work as offering school staff the possibility of enabling "a thinking space to be created in which teachers can enhance their observational skills and develop their understanding about the emotional factors that impact on behaviour, learning and teaching"(p.144). The successful outcomes of the work discussion are illustrated by positive feedback from the head teacher and a survey completed by 25 members of staff, of whom 88 per cent felt that they had developed their skills in working with challenging and disruptive students.

Whilst there are many differences between working in a Children's Centre and working in a secondary school, the Therapeutic Playgroup on which my research is based also held weekly meetings for the team members following on from the playgroup. I chaired this meeting and, despite it being different from a work discussion group, one of the purposes of the meeting was to share observations of interactions between parents and infants and to consider the emotional responses to the families attending the service and how this might inform the work. Jackson's paper is relevant to my own research in the context of finding ways to work collaboratively with staff who have had different trainings and are from varied backgrounds. Jackson emphasises the importance of clear communication and, as with Urwin's work, the need to review and possibly revise aspects of the work at regular intervals. Both papers highlight the 'newness' of this type of work and yet there is an implicit suggestion that both models could be replicated by other Child Psychotherapists.

Dilys Daws (1985) writes about the work she carried out within a GP surgery with mothers and babies. She explores some of the issues that a child

psychotherapist faces as an outsider working within an institution. The work involved working with a range of health professionals and families, which she describes as "brief psychotherapeutic consultation" (p.77). She thus named her role "consultant" (p.77) and she states that the "crucial issue is *where to put oneself"* (p. 78)*.* By comparing her role as outsider with an anthropologist, Daws suggests that if the anthropologist were to "settle in to become part of a culture, her scientific value is endangered" (p.78). This analogy applies to the child psychotherapist in arguably any outreach setting including a baby clinic.

Daws highlights the problem of spending too much time on clinical work with parents and babies who are considered to be in particular need and how this attention may lead to feeling overwhelmed by the work. Staff may also consider the Child Psychotherapist to be unavailable because s (he) is not visible. Daws articulates the process of understanding how her role might be most effective:

> The usefulness in sharing ideas about the problems of mothers and babies with my colleagues; furthermore, that the timing of good referrals was partly dependent on the timing of informal discussions with me. I realised I must be visible, available and receptive (pp. 78-79).

Finding where to stand was a gradual process for Daws. She identified "next to the weighing scales" as being a central point within the clinic. She states:

> …standing doing nothing requires skill if it is not to be puzzling and persecuting to the people around…If I am too self-contained, it must seem that my observations are for some unexplained private use; if I am too efficiently outgoing, mothers hand me their Baby Books to check them into the clinic. (p.79)

Daws is suggesting that there is a delicate balance to be struck between establishing your role and becoming too available when finding a role within a community setting. Getting it wrong seems to be an almost inevitable part of the process.

Daws makes an interesting point in reference to her psychoanalytic framework of understanding.

> I do not believe that I am the only holder of a psychodynamic viewpoint. We would do well to acknowledge, as members of the psychotherapy professions, that we came to these professions because psychoanalytic thinking is embedded in present-day culture- the culture did not arise because of us. Our contribution is to keep it in circulation in spite of our own, as well as our colleagues many resistances. (p.80)

This thinking would appear to warn against the role of the 'special individual,' who is seen by the organisation, or by some members of the organisation as being different or upholding knowledge or thinking that is superior or different from other knowledge. Daws suggests a more inclusive way of seeing oneself as a psychoanalytic practitioner with a function within an organisation; "my task is in reinforcing this approach in my colleagues, not in allowing it to be attributed only to me"(p.80).

Daws' work is relevant to the research in many ways but has particular resonance in terms of thinking about why another child psychotherapist was requested by the team to replace my predecessor. Rather than seeing the child psychotherapist as the 'holder of a psychodynamic viewpoint', my impression after starting in post was that the team felt that they applied many of the theoretical and practical concepts used in child psychotherapy, such as writing up observations, and talking about 'containment' and 'projections.' Rather than my predecessor being a provider of psychoanalytic insights, it appeared to me that psychoanalytic thinking was already present, to some extent, within the culture of the playgroup. It was important to learn that I wasn't seen as providing something unfamiliar or even distinct from what the culture of the playgroup already shared.

Daws' work is particularly important in the context of my study because of the way in which she develops a role that did not exist prior to her arrival, and she illustrates the time and thought required for this to grow and become valued.

In '*Sent before my time: A Child Psychotherapist's view of life on a neonatal intensive care unit,*' Margaret Cohen (2003) describes the process of developing and establishing her specific role within the team as being one that was quite distinct from the roles of the medical staff with whom she worked. For Cohen, the initial appeal of the job was located in the job description, "the post-holder would be expected to articulate the babies' experience" (p.9). She goes on to explore the difficulty in relation to what she experiences as a reluctance or resistance in some staff members to respond to being in touch with painful and frightening feelings linked to vulnerability and fear, life and death.

Cohen experienced her role at times as one of being the unwelcome reminder of a painful reality. This work is important within the context of the research because it provides insight into the challenges for a child psychotherapist in multidisciplinary settings. The child psychotherapist will attempt to express and explain painful, disturbing and frightening experiences on behalf of the team. Other professional trainings may not engage with thinking about the quality of experiences in the same depth as psychoanalytic trainings. This can sometimes create conflict within a team where other discourses are predominant or even prominent.

Cohen's account details her journey from applying for the job to the lived experience of meeting the challenges of the role and more specifically being in close proximity to both life and death, without the medical skills of the nurses and doctors. She draws the readers' attention to how isolating yet challenging the work could be at times. Such work appears to require patience, sensitive perseverance, careful processing and the ability to bear the pain of the staff as well as the patients. Cohen considers the different ways she could contribute to the work, in terms of work with parents but also through team meetings and supervision groups.

This work feels important in the context of the research because, unlike Jackson's (2008) and Urwin's work (2003), experiences are presented as successes and achievements, Cohen details the challenges in such a way that allows for learning how her role was used and seen within the institution. The work that I undertook in the playgroup was a similar learning experience and was not a straightforward process. At times I felt out of my depth and too inexperienced to be effective. Cohen draws attention to why some outreach work might be more complex than others.

Loshak, (2007), discusses her professional transition from a clinical setting to a psychoanalytic understanding of institutional and professional defences within a community setting. She states, "I have struggled to manage my own wish to maintain a distance, to avoid becoming too closely engaged with the work of any one team" (p.28). She describes herself as "entertaining the omnipotent belief that I alone understand and can provide for the needs of all these children" (Ibid., p.28). Her work explores the risks to one's professional identity not only as part of the transition to new settings but also in terms of a change in working relationships with colleagues. It also conveys the powerful urges to enact defences as a way of managing the anxiety inherent to the work. This links to the exploration of professional role and identity in my research and how it changes and adapts to the setting and the team one works within. The research is relevant in terms of understanding the struggle to establish one's professional role in a different setting, while still managing to carry out the complex work.

Bion's (1962) model of container/contained includes within it a communicative function in the relationship between the infant and his/her mother. His theory of thinking illustrates the way in which he sought to find a way to capture emotional qualities and their effect on objects.

> It is convenient to regard thinking as dependent on the successful outcome of two main mental developments. The first is the development of thoughts. They require an apparatus to cope with them. The second development therefore, is of this apparatus that I shall provisionally call

thinking. I repeat-thinking has to be called into existence to cope with thoughts. (Bion, 1962, p.110).

Containment is an extremely important theoretical concept in the many ways that it impacts upon my playgroup research. The team members made attempts to nurture a non-stigmatizing environment, a setting in which specialist support can be made use of in an informal setting. The concept of a "container" is important in terms of establishing one of the tasks of the playgroup as being to contain at least some of the families' anxieties. This was not always a straightforward task, since some of the work was about helping families to identify, or to think about their difficulties in a way that they may not have done previously. The model of containment also has relevance to the function of the team meeting part of which was to provide some thinking space for staff and so create some containment in terms of considering the impact of working with the families had on the staff. As Maiello, (2012) writes:

> The elemental simplicity of Bion's model is at the basis of its immense richness and flexibility. It can be observed in infinite variations both in everyday human relationships and in psychoanalytic work. Container and contained are in a dynamic relationship with one another in the dimension of space and time. The changing quality of the emotional link between the two components, which can be mutually creative or mutually destructive, opens the door to infinite options and transformations (p.266).

The concept of containment, in its many manifestations, can be identified as one of the aims in the work of the staff group and the institution. Whether a child psychotherapist can provide a specific quality or type of containment will be investigated in the analysis of the data.

Loshak, (2007), suggests that psychoanalyst Ron Britton's (1981, p.170), work about the anxieties that families using mental health services experience may also be helpful in understanding the impact of these families upon the professional team. Britton explains that the experience cannot be communicated in words, or as thoughts, but is instead "forcibly communicated

at an unconscious level to the professional network which is in danger of reacting with action rather than thinking" (p.170).

Britton, (Ibid.,) applies Wilfred Bion's (1962) concept of the 'container', to the process of professionals working with families. The 'container', exists in the capacity of the mother to reflect upon and thus to contain her infant's projections, as opposed to returning these to the infant unprocessed and undigested. Loshak suggests, "Where a worker has such a capacity, a space for thinking and is well supported externally, the idea of people coming together will be helpful rather than persecutory" (p.35). One way in which space for thinking is promoted is regular joint meetings, which bring professionals together, and "contain anxieties and reduce projections and blaming"(p. 35).

According to Britton (1981), many families are unlikely to access child mental health services because "a place like a clinic where problems are focused on seems threatening and even the collation of information is felt to be unwelcome" (p.170). This aspect of engagement is one that the Children's Centre in this study sought to overcome.

The examples discussed cover a range of settings and experiences of carrying out a 'field work' type of child psychotherapy. The anxiety experienced by the child psychotherapist or clinician, in the necessary adaptation to the new setting, is shared in most of the work, as is the need to nurture successful relationships with colleagues in a flexible and reflective manner. Building a role, over time, is a prevalent theme in this literature.

The History of Therapeutic Playgroups

A Child Psychotherapist, Joyce Robertson first started a group for mothers and toddlers at the Hampstead Clinic, now the Anna Freud Centre, in the 1950s. This first group was an 'informal off shoot from the Well-baby clinic, to help mothers to understand and respond to their infants' changing physical and emotional needs' (Zaphiriou-Woods 2012, p.350). Since the 1970s, groups have

continued to be run both at the Anna Freud Centre and in various outreach settings, for example in a homeless shelter for women and in community centres. The 'overarching aim' (Ibid.,) of the toddler groups is to promote toddler development. This can include 'enhancing attunement and attachment between parents and toddlers and facilitating separation and individuation'. (pp. 350-1). Zaphiriou-Woods highlights the vital role staff play in communicating on behalf of the child. 'The staff may speak directly to the child about what he is feeling or for or about the child's emotional state.' She suggests the aim of this way of speaking is to raise parents' awareness of toddler states of mind.

Zaphiriou-Woods (2010) charts the history and the function of the 'toddler group' as developed at the Anna Freud Centre.

> They are characterised by their leadership by trained professionals in on-going consultation with a child psychotherapist. Observations are kept by group leaders/head teachers, their assistants and student observers. They form the basis of weekly seminars and discussions in which interventions are planned according to our understanding of each child's individual developmental needs. (p.210)

She highlights the important preventative work that can be achieved in a toddler group setting and concludes:

> Toddler groups and nurseries are in an ideal position to help, both by accessing young children and their parents at a time when both are especially amenable to change, and offering them relationships and experiences which encourage mutuality and progressive development'. (p.231)

During the 1970s and 1980s similar work was developing from the Tavistock Clinic into local Young Family Centres, with the aim of engaging families who might now be described as 'hard to reach'.

Hoxter (1981) writes, 'It seems to me that, particularly in the case of very young children […] the institutions in which they are placed for day care […] are likely actually to produce problems of mental and emotional disturbance, of insecurity and lack of containment' (p. 3). She describes her work as a 'staff consultant to

an unusual day-care centre for young children' (p. 5). She suggests what makes it unusual is the staff, who are aiming to train as child psychotherapists.

> There is a consistent concern to devise ways of improving the quality of the work, to provide children with opportunities for experiencing intimate and constant relationships. […] Mothers are encouraged to spend a good deal of time at the centre and attempts are made to help these mothers and to strengthen the relationship between mother and child. (p.6)

This work predates the playgroups that were established by Urwin (2002) and the playgroup at the centre of my study, and yet the tradition and continuity of the model is clear, in terms of the commitment to engaging families and encouraging parents to think about their children and for preventative work to be undertaken within an inclusive and welcoming setting.

Multi-agency and multidisciplinary research literature

There is a broad range of literature describing research into multi agency and multi disciplinary work with families that has some relevance to the research, despite being carried out by clinicians from a variety of fields such as psychology, social work and adult psychotherapy, as opposed to child psychotherapists.

Salmon and Rapport (2005) have completed a qualitative study, which explores the discourse between multidisciplinary professionals from a Child and Adolescent Mental Health service in different meetings. The authors were interested in the language used by different clinicians and the misunderstandings and assumptions that might occur when certain language is used. The study consisted of recordings of meetings involving CAMHS clinicians and members of other agencies, such as Social Care and Education. In a link to my research, the researchers were also clinicians within the team she was researching, so the role of 'clinician researcher' played an important part in the research.

The paper suggests that it is not surprising that there is more literature about the challenges of multi-agency collaboration and the barriers to it occurring in practise than there is about factors which improve the likelihood of its success. The difficulties in communication between agencies are cited as one of the most significant challenges, suggesting that professionals use the same words as each other but, "apportion them with different meanings" (p.430).

The emerging themes following analysis included "discourse around intervention". One finding was that "conversations between professionals about interventions frequently refer to the perceived lack of willingness shown by a family to take up offers of help from an agency" (Ibid., p.430). This can result in some professionals speaking about "bending over backwards" or going "beyond the call of duty" in their efforts to try to be helpful. The study suggests that while professionals frequently ask questions to clarify facts about families and children, "requests for or attempts to clarify terminology occur far less frequently" (Ibid., p. 435). The authors speculate that the reasons for this are possibly linked to perceived hierarchies within the meetings and they conclude that the "culture both within individual agencies and in multi-agency meetings needs to be such that clarification of meaning is actively encouraged" (Ibid. p.440).

The study by Salmon and Rapport (2005) is firmly located within the legislative framework of the Children Act (2004), and Every Child Matters, (2004), which were written following the death of Victoria Climbié. The study is concerned with understanding how risk is thought about and spoken about in a team. The words that a staff group use to talk about their work is of relevance to my research because I am interested in how different staff members describe their work, including the detection and management of risk, and whether language is used to describe the same or different phenomena. A significant difference between the Salmon and Rapport research and this study relates to the setting and its relationship to the clinician researchers. It was the CAMHS clinic which

was the setting for their study, whereas I am concerned with the specific Children's Centre.

Jo Rose's (2011) paper which examines the dilemmas of inter-professional collaboration is based on a large study, encompassing members of 8 inter-professional teams working in different areas of children's services who discussed their thoughts on three hypothetical but realistic examples of inter-professional dilemmas. The emergent themes are named as "identity, power, territory and expertise" (p.151). Rose's paper aims to conceptualise inter-professional dilemmas in three ways, which she defines as around role, identity and control.

The study consisted of fifty four semi-structured interviews which were carried out with members from CAMHS, Special Educational Needs Staff and Social Care teams. The study revealed that a "practitioner faced a decision between being immersed in their specialism, or broadening out their field of practice" (p.157), with loss appearing to be a significant experience. Several participants highlighted that if too much multi-agency work was carried out, it became harder to retain a specialism. This led to comments such as the specialism being described as "where their roots were and several participants suggested that in joint work there could be recognition for specialist contributions" (p.158). Thus an important outcome of the study was the way in which professionals were found to be territorial about their expertise, at times only wanting to share it when it suited their own purpose.

Rose's paper states that much of the research literature which explores inter-professional and partnership working identifies shared "purposes and common goals as important factors" (p.151) in successful working. Rose distinguishes between previous research on multi-agency working and her own research by suggesting that issues around identity, expertise, territory and power are "usually discussed as the result of collaborative work, not as factors that need to be negotiated in the pursuit of joint goals"(p.162).

Rose (2011) suggests that role dilemmas can result in "overlap" (152) in delivery, as well as creating anxiety around quality of services provision. She states that professionals often feel unclear about what being a "multi-agency professional" (p.153), means in practice, so it can be difficult to develop and feel secure with such an identity. Identity dilemmas and control dilemmas can arise when professionals have to deal with "contradictory models of practice in decision making, which can lead to feeling ignored, devalued, and potential confusion for service users" (p.153). In describing what she calls "collective preferences", Rose states that these are enacted when the group prefers and intends to achieve the best outcome "for the group and the individual acts as part of the group to achieve this outcome" (Ibid., p.152). The questions in the study centre upon whether professionals believe that enacting collective preferences would be a desirable resolution to role, identity and control dilemmas.

Some participants described how they felt some professionals had significant professional responsibility and high levels of expertise, which led to other professionals being more likely to accept their authority. The "force" of individual personality and persuasiveness was also seen as influencing decision-making. "There was a tendency for some to adhere to the rhetoric of shared goals without going beyond that to consider the details of meeting such goals" (p.161). Rose links her findings to other multidisciplinary team research literature, in which terms such as "shared goals" are agreed upon, without a clear understanding of what this means. Rose suggests that professionals may "have to adjust to a conceptualisation of themselves as non-specialists; or accept that achieving the teams goals may not always entail use of their specialist knowledge" (Ibid., p.161).

Rose concludes that the specific contribution she makes to the debate is to show that enacting collective preferences may entail some kind of professional self-sacrifice. Her study is relevant to my research because of the way it thinks about the differences between a 'specialism' and working collectively as part of

a multidisciplinary team. The concept of loss, as opposed to self-sacrifice, in relation to working differently, or as a part of a collective staff group, is an important idea within the context of my own research study.

One further consideration to be raised in relation to Rose's research was the use of the hypothetical scenarios presented to the participants and how this may have affected the way in which they responded. On the one hand this may have led to thinking in a more realistic way, because it is not personalised and therefore may be more likely to provoke uncensored responses. On the other, it can be argued that the hypothetical scenarios provoked responses which were not entirely based on the lived experiences of the reality of work. I constructed the schedule of questions, which form part of this thesis in such a way as to understand professional identity as being more than simply a way of discussing the work.

Jo Warin's study, (2007) focuses on the evaluation of three community centres. She states that the purpose of the study is to expose the conflict of goals that underlies policy initiatives in childcare, to show how this is reflected in tensions in multi-agency working, and to call for goals to be clarified and to be "centred on the child-within the family as the beneficiary of services" (p.88). Warin's principal question was "Is the service conceptualized as serving the needs of the child, parents, mothers, fathers, the child-within-the-family, the extended family?" (p.91) This question is explored in the context of the work with families that the staff group describe.

Strategies in which government departments are collaborating and which are models of "joined up thinking", are highlighted in the study, but Warin suggests that such strategies may represent an attempt to "paper over the cracks" (p.92) between very different objectives. The paper suggests that the differences in understanding who or what the primary objective of the work is from a policy level may create confusion in the work itself. Understanding who the client/patient/service user is in my research is an important way of establishing what the primary tasks of the organisation are, and how these may be

interpreted differently by members of staff. I shall explore how these interpretations will come together to form a structure in my analysis of findings.

Nightingale and Scott, (1994) are Consultant Psychotherapists who examined the impact of organisational change within the multidisciplinary NHS team within which they worked. They wanted to understand the personal effects that system changes have had on staff. The authors highlight the way in which the delivery of adult mental health services undergoes change, "as the focus of delivery moves" from the large mental health hospital to the community services, with the consequence that staff are faced with the task of "learning new ways of working" (p.267). Both authors and senior members of staff joined the psychotherapy service during the three years preceding the writing of the paper, and they suggest that this has "resulted in a change of therapeutic focus away from social therapy and towards a clear identification of the psychoanalytical model" (p267).

One specific pressure cited was the way in which team members experienced pressure to be seen as "the same, in terms of competence, skills, seniority and training" (p.269). The authors noted that staff also felt under pressure to deny the limits to their professional capacity, because, according to the authors, this would "arouse unbearable anxiety," (p.269) in a similar way to Loshak's (2007) discussion of experiences of changing role and setting. The authors state that a "false certainty", or "pseudo knowing" began to pervade reports of sessions with patients (1994, p.269).

Discussions with the team resulted in the problem becoming conceptualized as a fear of being exposed, or "being found out". The authors understood the responses of the staff as institutional defences being mobilized, as well as "projective identification through which powerful feelings were split off and projected into others, specifically new members of staff" (p.270). In terms of the identity of the staff in this situation, the authors write that:

> Staff may be faced with a painful choice either to retain an awareness of their position as a nurse, occupational therapist etc., and working under supervision in a psychotherapy service or adopt an identity as a 'therapist', knowing that they have not undergone a training which would confer this identity (p.270).

Clarity of role definition, they write, has been vital in terms of resolving some of the anxieties experienced in the team.

This paper is relevant to my study in the way that it attempts to document, in psychoanalytic terms, the "manner in which individuals are affected by changes in their work systems" (p.273). The authors, as senior staff members and to some degree 'clinician researchers,' are in a unique position in relation to understanding what happens in the team. However, the paper does not provide us with the perspectives of the junior team members who are required to take on different roles and who are seen as the most likely to be exposed to projective identification.

This range of literature investigates issues such as the impact of change on teams, the complexity of carrying out multi disciplinary work and the way in which loss and self-sacrifice in terms of specialism or training might be necessary components to successfully working in a collaborative and multi-disciplinary way. These issues are of relevance to my study because of the changes that were taking place in the team, alongside attempting to understand the 'everyday' complexities of working and developing a role within a multidisciplinary context.

Cultural and ethnic considerations of the work

The literature which relates to the implications of working with ethnic and cultural diversity is relevant to both the families who used the playgroup and to the composition of the team itself.

In a paper describing psychoanalytically informed work with two Bangladeshi young women, a mother and an adolescent, Loshak (2003, p.53) highlights a

problem experienced by many helping professionals working across cultures. "Confronted with family patterns so distant from their own experience, and without a shared language, [they] can become overwhelmed and paralysed in their thinking and in their capacity to be of use". Loshak refers to an:

> …unconscious assumption that cultural difference cannot be understood and that therefore the work will be of limited value. This can lead to stereotypical responses, such as the notion of a 'culture clash', resulting in a dismissive attitude to the work, or a failure to engage with the grave seriousness of patients' situations and emotional disturbance (Ibid., p53).

She stresses the importance of working with and through the counter transference in these situations. This is echoed by Urwin (2003) when she suggests that professionals can be quick to make an assumption that owing to cultural difference it is not possible to understand the specific experience of the family.

Continuing her research into the role of ethnicity and identity, Urwin's (2007) paper, which follows on from her research into the formation of mothering identities in an inner London borough, describes how the researchers used psychoanalytic infant observation, alongside interviews, to explore aspects of changing identity in motherhood. They worked with a group of six women from ethnically and culturally diverse backgrounds who were all living in a deprived area.

Assessing one of the outcomes of the research, Urwin (2007) writes:

> All the mothers to a greater or lesser extent went through a period of what we have described as 'existential loneliness' in the first months postpartum, as they dealt with disruption to the life that existed previously and considerable internal change (p.248).

Urwin highlights separation between women's work at home and paid work outside the home is located within European cultures. We tend to think of a mother's responsibility for emotional aspects of the baby's development as "definitive" of her role whereas for many other cultures the responsibility for earning money and for contributing to the family income form an integral part of

mothering identity. These findings are important in terms of thinking about the families attending the playgroup, and how it was necessary to try to hold in mind the range of mothering experiences and identities brought to the playgroup.

<u>Outreach work and research</u>

There is a growing body of research, which aims to capture what outreach work is and what makes it most effective. 'Outreach' is an umbrella term encapsulating a huge body of initiatives and contact with communities. The institution where the research for this thesis took place is primarily outreach in its aims and purpose.

McGivney (2000) has attempted to understand participation issues in adult education, to define what 'outreach' work is. She states that, "There is no single and universally accepted definition of 'outreach', however:

> Most people interpret it as a process that involves going out from a specific organisation or centre to work in other locations with sets of people who typically do not or cannot avail themselves of the services of that centre. Whilst the central connotation of outreach is to physically go outside the institution (a staff activity), a number of other meanings have accrued to the word: activities to make people in different locations or groups aware of what an organisation or centre can offer (a marketing or recruitment strategy); provision of learning programmes in informal community locations (a delivery mechanism); liaison and contact with other organisations or particular sets of people (a networking process); working in particular ways with people outside the main centre or institution (a method or approach), as well as any number of other meanings. (McGivney 2000, p.11).

McGivney (Ibid., p.11) identifies four different outreach models of work:

• The satellite model: establishing stand alone, separate outreach centres for delivering services in community locations;
• the peripatetic model: delivering services in other organisational settings such as hostels, community centres, GP surgeries, housing offices, etc.;
• The detached outreach model: contacting people outside of agency or

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organisational settings, for example, in streets, shopping centres, pubs,
at school gates, etc.
• The domiciliary outreach model: visiting people in their own homes.

The Therapeutic Playgroup applied the peripatetic model in terms of the
specialist or professional branch of services offered to the client base. The
domiciliary model was applied by the Family Support Group. Arguably, one of
the aims of the institution was to move towards becoming a satellite model, in
which the need for other forms of outreach were not as essential once the
centre gained a reputation for delivering services within the community.

Davis, Dewson and Casebourne's (2006), study was commissioned by the
Department for Work and Pensions, with the purpose of establishing how the
scope of outreach initiatives could be developed in order to effectively
implement new initiatives, with a focus on welfare to work initiatives. The
authors conclude that assessing the outcomes from outreach is difficult.
Outcomes from outreach take longer to achieve as customers are harder-to-
reach and thus, by definition, usually harder-to-help. These customers are
normally disengaged from mainstream services and require some time and
investment in order to build their trust and confidence in the service.

Making generalisations about outreach work is misleading because it disguises
the breadth of their vision and the variety of the work. There is also a wide
variation in the aims and the purpose of outreach organisations. Understanding
the goals of the specific institution and the tasks that the staff undertake is one
of the purposes of the research.

Reflective Practice
Reflective practice is relevant to my study because of the way in which it seeks
to integrate theory and practice. The importance of a reflective practice
approach to work is that it encourages the individual or staff group to not only
look back on past actions and ways of working, but to also reflect upon the

resulting responses, experiences and actions. This will contribute to existing knowledge and will enable the development of new ways of working. The model of work in the Children's Centre called upon the staff group to try out new ways of working and to try to differentiate between what was effective and what was not effective.

Donald Schön (1983), developed ideas surrounding the capacity to "reflect on action," so as to engage in a process of continuous learning.

> The professionals are vehicles for the pre-emption of socially legitimate knowledge in the interest of social control […] the demystification of professional knowledge may have two quite different meanings. It may consist in treating professional knowledge as the emperor's new clothes; or it may mean that professionals do know something worth knowing, a limited something that is inherently describable and, at least in some measure, understandable by others. In this second sense, mystification consists in making knowledge-in-practice appear to be more complex, private, ineffable, and above all more […] closed to inquiry, than it needs to be. (p.288)

Joyce Scaife (2010) uses the example of crossing the road to suggest "reflection is creating an explanation of the experience, reviewing your usual practice, thinking of possible ways to approach the matter in the future and making a decision about your own future action" (p.2). Where reflective practice differs from work discussion as a model of learning is that there is no explicit use of the unconscious or free association in reflective practice. However, the way in which feelings and thoughts are valued as a way of informing reflective practice demonstrates similarities between them.

> Successful analytical reflection on practice should lead to learning and skill development because it involves maintaining a stance of curiosity and questioning automatic responses. Instead of doing things in the way that have habitually been done according to a manual or technical prescription, the worker feels, thinks and modifies what he or she is doing responsively to the ongoing process. (Ibid., p.5-6).

In my analysis of findings, I explore how the participants draw on learning from their training, or learning from experience of the work.

Of particular relevance to my own research is the way in which Schön explored the question of who the client is within the professional relationship. Schön considered it important to seek clarity on this matter. There may be different answers to this question so far as the members of the team are concerned. This may lead to a misunderstanding of common aims and to possible conflict between staff members.

Child Psychotherapy, Psychoanalysis and the Work discussion model

Margaret Rustin (2008) traces the historical origins and development of work discussion. She begins by addressing the way in which the model can "disappear as a distinctive category and become subsumed under more familiar educational activities, including reflective practice and clinical supervision" (p.3). She asserts that the distinctiveness of a work discussion approach is based on a "belief in the central importance of the emotional dynamics of experience at work" (p.4), which entails a "focus on those feelings, both conscious and unconscious, evoked in the worker by the task, context, institutional constraints, and daily relationships". (p.4)

Martha Harris, a psychoanalyst and Child Psychotherapist, offered the first defined work discussion seminar at the Tavistock Clinic. Rustin quotes Harris' description of what she sought to achieve, as described in the essence of what she wanted to provide for the course outline of the psychoanalytic observational studies course.

> Students bring detailed studies of their work for discussion in seminars […] No particular technique is taught in these seminars[…] The aim of the seminar is to sharpen perceptions and to enhance the exercise of the imagination so that a richer understanding of the personality interactions described may ensue. (p.5)

Rustin locates the development of the work discussion method in the 1960s, being a period of educational and social change.

> The democratization of the insights of psychoanalysis was an evident component of the concept of work discussion, since it operated on the

basis that people of very varied levels of professional status and experience could learn from each other and also assumed that the unconscious could be explored not only on the psychoanalytic couch but also through free group discussion of emotionally significant events from the workplace. (p.7)

Rustin considers the work of Bion (1962) to be a crucial influence on the development of work discussion, being based upon Bion's work on group phenomena, and ideas about how group life could be understood to have therapeutic and developmental potential.

> The work discussion group probably derived its name, in part, form W.R Bion's valuing of the working potential of a group that is able to avoid falling into the "basic assumptions" of dependence, pairing, and fight/flight and to enlist, instead, the ego capacities of its members to tackle the agreed task, to become a "work-group"[…] *Not* knowing is held to be a primary requirement of being able to "get to know" something. (p.20)

There is no expectation of finding an answer, but a commitment to facilitating thought. To do this, the individuals and the group between them need to hold aspects of the material in mind, "to learn to listen, to appreciate the containing potential of setting and institution, to think about what might be helpful" (p.20), as well as to consider others' perceptions of the situation.

The particular significance of the method in relation to this research can be linked to the way in which "unexpected ideas and conflicts" arise relating to the role of a teacher, or psychologist or social worker.

Work discussion has played an important part in my training. Bearing "not knowing" and being able to 'get to know,' gradually and without certainty, informed my approach to the Therapeutic Playgroup, as well as to the way in which the team came together to do the work.

One of the explorations within the conclusion of the research is to consider whether a work discussion group might have contributed a helpful containing

function for the staff, as well as an opportunity to think about the work outside of the more formal structure of a meeting.

Open Systems Theory

Open Systems theory states that any enterprise may share characteristics with a biological organism. An open system exists, and can only exist, by exchanging materials with its environment. This offers insights into the importance of primary tasks within institutions such as hospitals and factories, as well as having relevance to smaller enterprises such as a Children's Centre. This theory is illustrated using the example of an educational enterprise devised by Miller and Rice (1967). The authors suggest that students are imported, they are taught and are provided with "opportunities to learn; it exports ex-students who have either acquired some qualification, or failed". (p.3)

The authors explore the different types of enterprise, both in terms of the individual, the small group and the larger group. In describing the enterprise as a group, the authors state that the "existence of a group presupposes some emotional investment by its members in the identity of the group and hence in the preservation of the boundary round it" (pp. 20-21).

Open systems theory asserts that the individual, the small or larger group and the whole organisation demonstrate, in increasing levels of complexity, the same basic structural principle. Each one can be described in terms of internal world, external environment and boundary function.

Miller and Rice (1967), defined the concept of the primary task as:

> …essentially a heuristic concept, which allows us to explore the ordering of multiple activities. It makes it possible to construct and compare different organisational models of an enterprise based on different definitions of its primary task; and to compare the organisations of different enterprises with the same or different primary task (p.25).

There can be temporary shifts in the primary task, which can lead to a redefinition. Miller and Rice provide the example of a teaching hospital to illustrate this point.

> To survive, it must import medical students, train them, and export an acceptable proportion of them as qualified doctors; and it must also import patients, treat them, and export an acceptable proportion of them as convalescents. At any one time, one task or the other has priority and in the operating theatre the primary task may shift from moment to moment according to the progress of the operation (p. 27).

The authors warn that if the leaders of an enterprise fail to define the primary task appropriately, the survival of the enterprise will be threatened. Obholzer and Miller (2004) state that however the concept of the primary task is defined "its importance to institutional functioning is that an on-going debate must be held about what the institution is about and where it is heading." (p.35).

Lawrence (1985) suggests:

> In a complex enterprise there will be a series of related task systems alongside the dominant task system […] Within each such task system there will be roles and sets of activities and relationships that are available for individuals who cross the boundary of the enterprise to take up employment. (p.235)

Lawrence makes a distinction between three different forms of primary task:

> The *normative* primary task that is the task that people in an organisation ought to pursue (usually according to the definition of a superordinate authority).
> The *existential* primary task that they believe they are carrying out, and the *phenomenal* primary task that it is hypothesised that they are engaged in and of which they may not be consciously aware. (p.236)

Miller (1993) writes that the concept of 'primary task' ought to be looked upon not 'as a property of an organisation but as an exploratory tool of the consultant-client relationship' (p.18).

Miller suggests:

> The approach is not prescriptive in the sense of telling people what they ought to do; but is does involve drawing attention to factors that members

of a group need to take into account if they desire to pursue its stated task more efficiently'. (Ibid.,)

Open Systems Theory and the idea of a Primary Task were relevant in this research particularly because in this multi-disciplinary and somewhat experimental environment, it was not straightforward to grasp what the central purposes of the work were. This was a particular issue in regard the role I was being asked to take up, and the diffuse expectations that seemed to be placed on it. My research sought to clarify the meanings which the different members of the team gave to their roles and where they were located within the institution. The concept of the primary task and the distinctions between tasks made by Lawrence were valuable in this.

These enabled me to conceptualise differences between the original goals and methods of the Therapeutic Playgroup which were inclusive and multi-disciplinary, and a more conventional hierarchical approach to its work to which it regressed as the institution felt itself to be under attack.

Roles and role theory

According to the American sociologist, Ralph H. Turner (1962, 1978), individuals do not equally embrace all identities associated with roles. Individuals vary in the extent to which they are committed to or identify with their different roles. Turner (1962, 1978) wrote of *the role-person merger*, the process through which the person becomes what his or her role is, rather than merely performing a particular role in a given situation.

Turner (1962) suggested that every role is a way of:

> …relating to other-roles in a situation. A role cannot exist without one or more relevant other-roles toward which it is orientated. The example is given of the role of 'father' being defined only in relation as a pattern of behaviour in relation to the pattern of behaviour of a child. (p.23)

Within the context of organisations, Turner (1962) writes that a role becomes a 'working compromise between the formalized role prescriptions and the more flexible operation of the role-taking process' (p.23).

Interactionist theory begins by postulating a tendency to create and modify conceptions of self and other roles as a key orienting process in social interaction. Turner (1978, p.234) states that 'the critical observation is that people behave as if there were roles'.

My study is exploring the roles that a number of people developed in relation to working within a Therapeutic Playgroup. Understanding how the roles were developed and how they changed over time will be examined in relation to the data generated.

Psychoanalysis and Organisations.

The contribution psychoanalysis has made to trying to understand the emotional life of organisations dates back to 1947, with The Tavistock Institute of Human Relations being formally founded as a registered charity. The early work of the Institute involved bringing together staff from different disciplines to find ways to apply psychoanalytic and open systems concepts to group and organisational life. This developed into 'action research':

> Through these collaborations our team developed new participative approaches to organisation change and development. These include: socio-technical systems design to help clients grapple with the emerging changes in the organisation's context, encompassing job-, work- and organisation design for joint optimisation of both technical and psycho-social resources. This was initially developed through collaboration in English coalmines (Trist & Bamforth, 1951) and Indian textile mills (Rice & Miller, 1953). (Tavistock Institute)

This work, often referred to as part of the 'Tavistock Tradition', is increasingly being referred to as "socio-analysis",

> The activity of consultancy and action research that combines and synthesises methodologies derived from psycho-analysis, group relations theory, social systems thinking, and organisational behaviour. (Bain, 1998, p.2)

A seminal paper by Isabel Menzies Lyth, (1959), a psychoanalyst, is an early

example of psychoanalytic work exploring the emotional experiences of organisations. The study was commissioned by a London teaching hospital. The Tavistock Institute was asked to investigate a problem related to student nurses leaving their posts following on from qualification.

The study began with an intensive interviewing programme with around 70 nurses, individually and in groups, as well as observational studies. During these interviews staff were invited to raise issues which they considered important to their experience of work. Menzies Lyth was struck by the role anxiety played in the work of the nurse.

> We found it hard to understand how nurses could tolerate so much anxiety and, indeed, we found much evidence that they could not…withdrawal from duty was common (p.45).

The origin of anxiety that mobilizes defences is understood by Menzies Lyth as a response to the "objective situation," (p.46); the work of nursing arouses strong and mixed feelings in the nurse: "pity, compassion and love; guilt and anxiety; hatred and resentment of the patients who arouse these strong feelings; envy of the care given to the patient" (Ibid., p46).

Menzies Lyth draws attention to the primitive and overwhelming power of these emotions, tracing the anxieties back to early infancy. She explores the techniques applied within the organisation to evade or defend against anxiety, the social defence systems, which she describes as developing over time as "the result of collusive interaction and agreement, often unconscious, between members of the organisation". (p.51) She describes the importance of the hierarchical structure within the nursing team, which enables a process of projection. Another defence she observed was the way in which nurses were discouraged from expressing emotion or interest in individual patients, she gave the example of a nurse referring to "the liver in bed 10" (p.52).

One of the key observations made in the study was that large numbers of nursing students did not complete their training and that it was often the more thoughtful trainees that left the training, unable to obtain job satisfaction, while those who felt able to follow simple orders were the nurses who stayed. For those who left, she found that there was a struggle to articulate and formulate why it was that they had wanted to leave. However the "general content of the interviews left little doubt that they were distressed about the inhibition of their personal development" (p.76). Menzies Lyth concludes that the "social defence system of the hospital was built of primitive psychic defences, those characteristic of the earliest phases of infancy". (p.74)

Writing Menzies Lyth's obituary, (The Guardian Newspaper, 2008) Tim Dartington states: "Her message remains relevant to NHS management today, and it was her regret that it had less influence than it should". The study has nevertheless continued to be examined and commented upon and thought about. Armstrong and Rustin (2012), suggest that one could read her findings as "reflecting the imposition in a medical culture of a hierarchical paradigm that mirrored the fragmentation and mechanisation of the factory system" (pp.1-13). Bain, (1998), suggests that what was crucial about the social defences Menzies Lyth identified was that they were operating for the most part unconsciously; they were deeply ingrained in the system and were very difficult to change, "And most importantly, what needs to be stressed is that the social defences were maladaptive for carrying out the primary task of the hospital in an effective way" (p.3). Both Menzies Lyth and Alastair Bain noted the phenomenon of 'multiple indiscriminate care' as a defence against anxiety. Bain, (1998) writes that part of the difficulty in modifying the social defences within a particular institution, is "because they are an expression of system domain fabric, and are not "stand alone" institutions" (p.4). He concludes that if Menzies Lyth had been successful in introducing changes within the nursing system in the hospital, "it is likely that the changes would have been washed away over time due to the nursing system being part of a wider system domain of defences." (p.5)

A project that took place between 1976 and 1979 in a day nursery for children

under the age of 5 is cited by Bain, (1998). The aim of the project was to design and implement an optimum system of care. As awareness of the social defences against anxiety developed, alternative methods of exploring and modifying this anxiety became possible. Bain identifies the introduction of regular weekly staff meetings with no fixed agenda, the consultants meetings with staff and organisational role analysis sessions with the officer in charge that provided the "learning spaces" for the project.

It is my view that the Therapeutic Playgroup was organised so as to attempt to ensure that staff members avoided unconscious defences of the depersonalising kind that Menzies Lyth describes, and that this was one of its strengths. One of the qualities valued in the role of the child psychotherapist was her capacity to keep feelings in mind. However, my findings did suggest that sometimes staff members' focus on the difficulties of parents might be a way of avoiding becoming too close to the distresses of their children.

Further significant psychoanalytic organisational work by David Armstrong and Clare Huffington (2004) suggest the importance of

> …Charting the various ways in which organisations can get caught in evolving structures and ways of working that are designed to evade the burden of those demands as we register them internally is essential. (p. 24)

The demands of the work and how this was managed by the staff group is investigated in the study. A distinction is made by Stokes (1994, p.121) between the "relatively stable aims" of an institution and the "relatively more flexible and changeable connotations of an organisation". He writes that an organisation might have a publicly "stated idea" of its primary purpose, whilst in parallel there are also often hidden conceptions at work. "Put simply, here is the level of 'what we say we do' but there are also the levels of 'what we really believe we are doing' and also 'what is actually going on" (p. 121). He writes that members of the organisation may be unconscious of this and be also unaware of the way in

which relationships to institutions have changed owing to the lack of permanence of institutions.

> A good old-fashioned institution provides something that we can really love or something we can really hate. And it will be there tomorrow, no matter how hard we love or hate it. Nowadays, one is hard pressed to find such a thing […] certainly the people may not be, and certainly the task is continually changing. As a result, institutions are not so available for the working out and working through of the ambivalent feelings surrounding work that each individual has. […] this causes anxiety. (Ibid., p.121)

The result Stokes concludes is

> …the widely shared experience of an increase in interpersonal tension and personal stress within sub-groups inside organisations, instead of the more familiar and simpler tension between workers and management. (Ibid., p.122)

Stokes' observations are particularly relevant to the prevailing and political climate in which my research was conducted. During a time of redundancy and cuts to the service, the more difficult aspects of the Therapeutic Playgroup came to the fore, and these ideas were helpful in terms of how to think about the impact of uncertainty upon the staff group.

Vega Zagier Roberts (1994) uses the term "the self-assigned impossible task" (p.110) to explain teams and organisations that are set up as alternatives to often more traditional ones, "often by someone disaffected by personal or professional experience of other settings." (Ibid.,p110) Roberts suggests that the difficulty of an identity based on being an alternative, implicitly suggests superiority, which can restrict debate. She writes, "Doubts and disagreement are projected, fuelling intergroup conflict, but within the group everyone must support the ideology. Any questioning from within the group is treated as a betrayal of a shared vision"(Ibid., p110). I consider Roberts' ideas in relation to the origins of the playgroups, and how they have developed over time, and whether the tasks of the playgroup had indeed become 'impossible'.

The "interpersonal" nature of organisations is how Armstrong and Huffington (2004) describe a psychoanalytic way of thinking about work. "Complex emotional constellations" (p.12) are aroused in the work place, and the particular contribution of psychoanalysis to understanding organisational life is in adding:

> …a many-layered account of the *ways* in which emotions shape our experience, both consciously and unconsciously; their origin in early object relations, their expression in phantasy, and their pervasiveness and distribution within and across our private and public lives (p.12).

For Armstrong and Huffington, organisations can be understood as "punctuations of interpersonal space, punctuations defined by the boundary conditions of the organisation" (2004 p.52).

Armstrong (2005) understands the meaning of the term "the organisation-in the-mind" as the "emotional reality of the organisation that is registered in him or her, that is infecting him or her, that can be owned or disowned, displaced or projected, denied, scotomized-that can also be known but unthought" (Ibid., p52). Armstrong and Huffington (2004) were influenced by the work of Wilfred Bion, whom they consider to have identified a link between his pioneering work with groups and his clinical work with individual patients.

According to Armstrong, to work analytically in organisations is to:

> …use one's alertness to the emotional experience presented in such settings as the medium for seeking to understand, formulate and interpret the relatedness of the individual to the group or the organisation. It is understanding that relatedness, I believe, which liberates the energy to discover what working and being in the group or the organisation can become (2005, p.33)

Armstrong (2007), uses the term 'lateral relations' to provisionally describe 'a relation between collaborating persons, role holders, groups or teams that is unmediated by any actual or assumed hierarchal authority' (p.194). He locates 'lateral relations' within two examples of organisational consultancy, which he

suggests are 'forcing us to reconsider or reframe some of the ways in which we have hitherto thought about the dynamics of leadership, management and authority'. (p194) Armstrong suggests that the examples he provides, while different, share themes of 'anxiety and vulnerability, in the dismantling of prior expectations and assumptions, both conscious and unconscious, and in the face of what might be termed the nakedness of being on one's own, with colleagues.' (p.195)

One example of a work place focuses on a multidisciplinary team in the public sector. Armstrong suggests that the organizational positioning of a team such as this is 'to say the least, awkward' (p. 203). 'There is 'no one vertical overarching body or boundary in view, though I think what might be termed our cultural distrust or anxiety around lateral relations contributes to the emergence of surrogates for such bodies, in the guise of commissioning and performance management arrangements.' (p. 202)

Within a public sector organisation such as this, Armstrong suggests that there is difficulty in 'how to reconcile the sense of difference in the acknowledgement of sameness'. (p.204) The team is faced with the task of having to 'create a skin around itself, or a boundary of identity' (p.204)

> If the team is to take authority (lateral authority), as I think it must, for defining and shaping its own boundary, its own sense of sameness (for no one else has the experience out of which such a boundary can be both found and made), its members have to be prepared to risk finding themselves at odds with their own home base. (2007, p.204)

Hierarchy and leadership are closely examined in my study, in terms of how the playgroup had been formed and had developed by three significant members of the team, one of whom was my predecessor, and how this changed when they had all left. The way in which the remaining team members tried to adapt or 'create a skin' is considered in the findings. The psychoanalytic approach to understanding organisational life will be applied to my observations of the

playgroup, the interview data and the journal that I kept, in attempting to understand the way the team operated.

Concluding Remarks

Overall, this broad range of literature touches upon many different theoretical concepts that are supported by research based work; and my research aims to understand something specific about the experience of being part of a service and to analyse how it functions in an honest and reflective way, both from my own experience and various perspectives of the staff group. I aim to build on a growing body of work that is based upon the experience of the child psychotherapist working outside the clinic.

Chapter 3

Methodology

Introduction

The research I carried out was primarily concerned with understanding how a multi disciplinary staff group described their work and how they understood the role of the child psychotherapist within this work. The work was a playgroup located in a Children's Centre. The initial intention of the research was to establish whether there was something specific and unique that a child psychotherapist could provide to this example of outreach work. Because I was working in the institution I was researching, methodological considerations arose that required careful planning and thought.

I found it useful to survey opinions as widely as possible for the purpose of my research. Staff members with different levels of experience of the service were also invited to participate in the research. Some of them had left the service prior to the interviews, whilst others continued to be part of the service.

When I first wrote the proposal for the study, the title I chose was 'An Exploration into What a Child Psychotherapy Perspective Provides in Multidisciplinary, Multiagency Team Work within a Children's Centre'.

As I began to write the interview schedule and think in more detail about the research and what I was trying to understand, I decided to change the focus of the title away from the role of the child psychotherapist specifically, to:

'How do members of a multidisciplinary team involved in running a Therapeutic Playgroup understand their role in the work?'

I decided to make this change partly because the original title felt more appropriate to a study in which I wasn't a clinician-researcher; for example if I

had been attempting to research my predecessor's role from the perspective of an outsider coming into the institution solely to carry out this research. As it was, I was part of the work of the institution itself and I felt that, by approaching the research from a broader institutional perspective, I would achieve a deeper insight into the playgroup. I would also be able to consider how the work might have changed over time.

I moved away from concentrating upon the role of the child psychotherapist because it felt as though I would be asking my colleagues to talk exclusively about me and my work. This would be too personal and difficult a request to make of one's colleagues. My broadening of the title and focus has enabled a more forthright outcome from colleagues whilst still allowing for the different roles of individuals to be examined.

It was difficult at times to distinguish between my practical role as a child psychotherapist within the staff group and my role as a researcher involved in trying to understand the work of the staff group entity. My role as a child psychotherapist would stray into the research task, in part because the work was thought provoking and required reflection. The participant role was in itself so challenging, that it sometimes touched upon the role of participant-observer-researcher. This might be understood as one of the risks of researching in this way, because there is always the possibility that the primary aim of the research can become inseparable from the challenge of the practical role. As it was, I felt that with separate supervision for the research and the work itself, I was able to pursue my key interest in the role of the child psychotherapist within the broader context of the team and the institution.

The study is an action research project, because I was investigating a situation in which my own role and the role of my predecessor was central to the project. It would have been a more straightforward study if I had been a research-observer studying the child psychotherapist's role in the Centre at

the time that my predecessor was the Child Psychotherapist. My situation was more complex.

The term 'action research' includes a number of different approaches to research. One form of action research involves the roles of researcher and participant as separate, but in this case there could be no such separation. I had to achieve the separation therefore in my own practice, trying to take a "third position" (Britton, 1989) on my own role. This is a difficult thing to do, and it required careful thought and supervision. I return to a discussion of action research later in this chapter.

A qualitative approach

It was a study in which qualitative methods were essential. The main reason for this was that it was unavoidably an exploratory study, generating descriptions and hypotheses, rather than 'testing' theories or measuring cause and effect. One argument for qualitative methods, which I think is relevant to this study, is that they are good for description and for the generating of hypotheses, but not suited to generalisation or for establishing causal relations.

The power of qualitative research is in its focus on the specific detail of a given phenomenon. The main consideration, therefore, was: how does this staff group understand their role in the work and others' roles in the work?

Clifford Geertz's idea of "thick description" (1973, p.3) is relevant in the context of the research, since a thick description of human behavior is one that explains not just the behaviour, but its meaning and cultural context as well, such that the behaviour becomes meaningful to an outsider. Geertz was describing anthropological work in which his presupposition was that the social world is being created by the actors, and interpreted by the researcher.

A single case study

A related aspect of this necessity for a qualitative approach was that this was in effect a single case study, in this case an organisation rather than an individual. Giving as full a description of it as I could, and seeking to work out the interrelations of different aspects of the situation was what felt appropriate for the study. Different aspects of the situation which emerged as being significant during the study included the threats to the Centre's future, the complexities of inter-professional relationships, the loss of senior staff and the fact that I was junior to my predecessor. In addition to these factors, I started in post after an interval of time during which there had been no CAMHS contribution to the playgroup. The whole situation was a learning situation for everyone, with few protocols or rules laid down in advance – this was both a source of the creativity within the work and the study, and also the source of some difficulties which needed to be considered within the context of the research, as opposed to being avoided.

The history of action research

Action research is described as giving "credence to the development of powers of reflective thought, discussion, decision and action by ordinary people participating in collective research on "private troubles" that they have in common" (Adelman, 1993, p.8). Kurt Lewin (1890-1947), whose first ideas on what he called 'action research' were set out in about 1934, came to describe its characteristics after a series of practical experiences. Following on from these experiences, Lewin stated "No action without research; no research without action" (1958, p.201). Lewin is an influential and important figure in the development of the work of the Tavistock Institute of Human Relations.

Lewin and his students conducted quasi-experimental tests in factory and neighbourhood settings to demonstrate, "the greater gains in productivity

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and in law and order through democratic participation rather than autocratic coercion" (Adelman, 1993, p.7). Lewin demonstrated that there was an effective alternative to "scientific management," as well as researching how to "develop social relationships of groups and between groups to sustain communication and co-operation" (1993, p.7). The experiment consisted of Lewin dividing the work force into two groups. The first received direct training given didactically with little opportunity to raise questions. The second group was encouraged to discuss and decide on the division of tasks and comment on the training that was given. Over several months the productivity of the second group was consistently higher than that of the first. The staff of the second group learnt the tasks faster and their morale remained high, whereas in the first group morale remained low. Lewin's observations and belief in a democratic rather than autocratic workplace appeared to be justified by the outcome of this experiment. The ultimate objective of action research is to improve practice in some way.

The method is criticised for lacking scientific rigour, a criticism that is responded to by Cohen, Manion Morrison (2007) in their suggestion that it is not a surprising claim, "since the very factors which make it distinctively what it is, and therefore of value in certain contexts- are the antithesis of true experimental research" (p.193). The authors list the criticisms of the method as "the fact that its objective is usually situational and specific, its sample is restrictive and unrepresentative, it has little or no control over independent variables; and its findings are not generalizable" (p.193). However, if action research were to be more extensively applied, "became more standardized, less personalized" then arguably some of these strictures would become less valid. (pp.193-4)

Action research is considered appropriate when specific knowledge is required for a specific problem in a specific situation, in this case a playgroup hosted within a wider institution. The problem was to attempt to establish what the primary tasks of the organisation were and whether they were fulfilled by the team, as well as to consider whether a child psychotherapist might provide a

distinctive contribution to the tasks defined by the institution. The action research method may be applied to any Children's Centre employing a multi-disciplinary; inter agency approach to a group session, that involved a child psychotherapist.

Further support for the method is provided by Cohen et al (2007) in the assertion that action research "addresses itself to personal functioning, human relations and morale, and is thus concerned with people's job efficiency, their motivations, relationships and general well-being" (p.187-8) which fits with the aims of my study. Lewin's work suggests that by interacting with an organization and its members, its qualities become known.

There were two dimensions of action research in my work. The first, in my role as a child psychotherapist, and the second as a researcher. In the first dimension, my perceptions and insights are intended for those I was working with in the practical setting, both staff and parents in the Therapeutic Playgroup. In the second dimension, when I will report my research findings in writing, the audience is likely to be mainly outside of the institution, such as child psychotherapists and others who may read about my research.

One type of action research involving clinical practitioners has been examined by Harrison, (1993). This study looks at the relationships between research and clinical practice in the nursing profession. Harrison suggests that there is "a wealth of evidence to suggest that the idea of research based nursing knowledge as informing the day to day practice of nurses remains in large measure at the level of professional rhetoric, rather than reality"(p.4). Harrison refers to the creation of the role of the clinical nurse researcher in the USA as a way in which clinical practice and research can become linked. The clinical experience and credibility of the clinical nurse researchers (CNR) were considered essential and the CNR was primarily located within the clinic. It is not yet known whether the role of the CNR helped make nursing research more relevant to practice as the role remains relatively new.

Harrison considers the literature on practitioners experiencing research as "alienating", "irrelevant" and "exploitative" (p.10), in regards to being used as "objects in the process", and suggests that there needs to be ways of

> …conceptualising and conducting research in which distinctions between researchers and participants are broken down, if not eliminated, and where research is a collaborative exercise so that there is joint ownership of the problem and the process. (p.10)

According to Harrison, the success of action research depends upon there being a commitment to change on the part of practitioners, as well as a realistic assessment built into the action expectations of practitioners' work demands and pressures. She further highlights the political, organisational and economic context that the nurse works in, and how one must be aware of this context in the development of research. Similarly, my research takes into account the economic and political reality the institution faced during the period of data collection.

This type of action research is one in which the action researcher involves the whole, or part of the workforce, in the research process, by sharing the observations and findings and attempting to implement them into practice. The model that I worked with in my research differed from this model in that I was trying to continue to carry out my role and at the same time research the process of it. My decision to take a research role came after I started to work in the institution and my colleagues were both participants and subjects in my research, but not co-researchers. When I explained the aims of my distinctive research to the staff group, I suggested that the findings of the study might produce some helpful information about how the playgroup functioned, which I would feed back.

Participants and recruitment

I spoke to the Children's Centre manager and my Service Supervisor and Manager in CAMHS about the possibility of conducting the research project with the staff group. The Children's Centre Manager agreed to the

suggestion and I began a process of consultation with my CAMHS manager, with the purpose of developing an appropriate proposal.

At a team meeting following on from the playgroup, I introduced the purpose of the research and invited all members of the staff group to participate in a recorded interview that was estimated to take 45 minutes. I explained that participation was voluntary.

Ten participants were invited to participate in the study and nine agreed to participate in the research[2]. My predecessor subsequently agreed to participate in the research meaning that there were ten participants. It is generally considered that a minimum sample size of eight participants is appropriate in a time-limited qualitative piece of research of this kind. This will generate an acceptable level of data, without being over-ambitious in terms of the six month time frame of the field research.

Once approval had been established the researcher began to meet with members of the staff group to distribute information and consent forms. Please see Appendix I and II.

Interview development

The interview schedule was developed over a month during supervision meetings. The scope and focus of the initial interview schedule was refined and adapted in order to reflect the changes taking place in the institution. In addition to the content and style of the questions, the language used as well as the length of the interview were important considerations. There was one formal pilot interview with a former colleague, who was a Child Psychotherapist who had worked in a different Children's Centre in a role comparable with my own role. This allowed for the semi-structured nature of the interviewing process to be practiced, because I hoped that the interview schedule would allow for

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[2] The non-response participant apologised and said she was too busy to be interviewed. This was a professional staff member who worked primarily outside of the organisation.

explorative and reflective discussion. Please see Appendix III for the interview schedule.

The tape recorder was not switched on for the preliminary stage of the interview. Instead, I explained the reasoning behind the interview and that it was not a test of any sort. The participants were reminded that the information they provided would not be linked in any way to their name or address and that strict anonymity would be maintained. Finally, they were told that if they discussed anything in the interview that they felt they would like to continue discussing afterwards, they could book an individual appointment with me.

Each interviewee was told that they were not obliged to participate. They were also told that even if they did agree to take part they could still refuse to answer certain questions and that they could ask for the interview to stop at any point. None of the participants asked for the interview to end early or expressed uneasiness with the process. They were then given a consent form to read and sign if they were comfortable with the arrangements. All the participating individuals provided their consent. I reminded the participants that the rest of the interview would be tape-recorded.

Warm up and interview

Once the preliminaries had been completed the recorded interview began. The recorder was switched on and the first question that I asked invited the participant to reflect upon how they had become involved in the playgroup. This opening question was chosen in order to generate a basic agenda for the interview. This question was also used as a way of introducing the general atmosphere of the process, which was essentially an organic discussion with no right or wrong answers. It was also a useful question to ask in terms of gaining insight into the personal history of the participant and the playgroup.

Efforts were made to blend the themes introduced by the participant with those that had been devised beforehand. Participants were given the chance to once more ask questions about the research and I asked if they wanted to add anything before finishing. The participant was then asked how they had felt about the process.

Interviews used in research

The decision to use a semi-structured interview was felt to be appropriate because, while it allowed for certain major questions to be asked in the same way for each interview, I was also free to probe for further information. In describing the merits of the semi structured interview Fielding (1993), writes:

> The interviewer is thus able to adapt the research instrument to the level of comprehension and articulacy of the respondent, and to handle the fact that in responding to a question, people often also provide answers to questions we were going to ask later. (p.136)

One of the reasons why a qualitative, semi-structured interview was chosen was because "people's knowledge, views, understandings, interpretations, experiences and interactions are meaningful properties of the social reality" (Mason, 1996, p.63), which the research questions were designed to explore.

Probing within the interview required careful thought because there were occasions in which the participant did not understand the question. I would repeat the question and then slightly re-phrase the question if this wasn't sufficient. At times I encouraged a fuller account of a response by saying "please tell me about that". The probing I employed was intended to be neutral and was concerned with encouraging the participant to give as full a response as the interview conditions permitted.

I transcribed the data, attempting to write down everything the participant said, including pauses in speech, laughter, and inhalations of breath. My

decision to transcribe verbatim was so that no data would be lost. This process helped me to familiarise myself with the data and to begin to make connections and identify initial themes for analysis. I also made notes of my thoughts during the transcription process.

After working as a member of the team, but not as a researcher, for approximately four months I introduced the research proposal to the staff group at the end of a team meeting. A senior member of the staff group said that she had participated in research before. She said that it was "good timing" in terms of the research having the ability to demonstrate the effectiveness of the model of work during a time in which cuts might soon take place. I explained that every staff group member was invited to participate in the research.

My understanding is that because the interviews took place at the end of my contract within the service, my role as clinician researcher proved less complicated than it might have done if I had remained in the service. Because I was leaving, and this was known by the staff group, the duality of the role of clinician researcher was perhaps less imposing than it might otherwise have been. I was in training, and the research could be located within my training and linked to my status as a temporary member of the staff group. Perhaps this felt less threatening or intrusive than research carried out by a permanent member of staff, who would then continue to work with the staff group. This would have required more reflection and processing at a team level.

It is possible to hypothesise that, because I was leaving, the staff group might have felt that the research had less importance to the work than if I was staying. Also, if I were staying, then the outcomes of the research could have been discussed and implemented in the team in an ongoing way. It is conceivable that the team might have felt more 'ownership' of the research if I had been a permanent staff member. In spite of this and of particular

importance to my outcomes was the belief held by some of the staff that the study may succeed in providing a way of saving the organisation.

Taking on a researcher role meant that I may have been perceived differently by the staff group. This required reflecting upon. My impression was that for some staff my role might have stirred up some professional rivalry, in the context of job losses and uncertain career futures. For those who had carried out research before, it might have felt difficult to be a participant and not the researcher. It was important to discuss in supervision and to manage in the interview de-brief and pre-interview conversation the perceived change in roles and the feelings that were thereby provoked.

While I do not think that my role as a researcher significantly interfered with the work I was doing with families in the Centre, I do think it likely that it had some effect. Although I tried to carry out interviews on days that I was not working in the Centre as a clinician, there was one occasion when I interviewed a staff member after the team meeting and this required a shift in role from clinician to clinician-researcher in a matter of minutes. This meant that the interview felt as though it was an extension to the work rather than something more removed or distinct from the working day.

If the research purposes of my role had been established when I first arrived in the team I think that this would have made a significant difference to how I was perceived. I think that I might have been seen as less of a clinician and more as someone from the 'outside,' who was looking in on the work for academic purposes; perhaps I would have been seen as removed from the day to day reality of the work itself. There might also have been a sense that I was doing this for my own benefit, for my own professional training and qualification, rather than for the team, or for the institution.

I think that these facts are relevant to how the research was perceived, regardless of the fact that the research was known about after I had been

working in the team for a period of time. There was evidence of some staff members feeling that the research might contribute positively to the evaluation of the service and there was also evidence to show that some staff members identified the research as being a necessary part of a professional training that they too had had to carry out in the past. There was therefore an understanding about the need for the recruitment of participants for the purposes of my research.

Becoming a participant-observer

Participant observation, when used in combination with interviews, offers a 'potentially powerful way to call into question the relationship between words and deeds' (Schwartz et al, 1979, p. 46).

A delicate balance is required for the participant observer to manage, around the involvement in the study and the threat that "too much involvement may cause the researcher to lose his objective, dispassionate scientific orientation". (Ibid., p48)

Having a research perspective helped me to think about the clinical work within a context of other child psychotherapy work; in schools, hospitals and other community settings. Reading about this work and being mindful of the experiences and challenges faced by other child psychotherapists helped me to think about the work within a broader professional context.

I kept a research journal so as to keep track of what I was seeing and learning. I started to do this after being in post for four months. The time restriction, linked to my fixed term contract, meant that I was under pressure related to complete the interviews. A number of interviews were cancelled or rearranged and I was concerned that I might not be able to complete the process in the time available to me. In this sense, the research did impinge upon my thinking about my clinical work in the Centre.

Keeping the playgroup and meetings separate from my research was at

times a challenge because after approximately five months I began to observe aspects of my playgroup work through the filter of my research. One example of this is illustrated by in an extract from my journal:

> Two members of the family support team stood at the front of the large table, during the gap between tidying away the plates, cups and fruit peels and beginning circle time, Family Support Worker 1 announced that in three weeks time the Centre would no longer provide a snack, owing to a change in budgets. Families were welcome to bring their own snacks in with them, and perhaps snacks can be shared with other children if there are enough 'to go around'. This was delivered in a loud, clear voice that did not give much opportunity to question or interrupt. The reaction of the families varied from irritation, 'what? How come?' To dismissive shrugs and a rejection of what was being said. Most parents busied themselves with their children, One parent commented to another that this was 'because of the government', which served to distance the sting that I felt might be experienced as something valued being taken away with out much warning. One parent said in a lighthearted but clear voice to the family support worker "oh you are evil!" The family support worker replied that she was 'just the messenger' and started to gather together the debris from snack time. (Source: Reflective Journal)

I reflected on how I had observed and had been a part of this situation afterwards. I wondered whether I had been slightly more removed from the situation than I might have been, less a participant, more an observer. Had I not been thinking about the research would I have played a more active role, commenting differently on what was being said and what I felt was happening?

With hindsight, I think that I was paying particularly close attention to what was unfolding, but simultaneously being more of an observer than participant in the situation. I felt that I was 'taking in more,' as opposed to merely responding in the moment. I was remembering the responses and thinking about what it meant for all of the families to receive this news. I thought about the choice of the word 'evil' and how this particular parent was experiencing the news of this loss of provision in a powerful way, and whether, despite the light hearted tone of voice, the blame was located in the staff member who delivered the news. If this were the case, one might begin

to imagine how the changes to the service impacted on the relationships between staff and families.

Looking back, I feel that I might have been able to contribute to interactions such as these by speaking more to staff, perhaps trying to identify the powerful emotions aroused by the cuts and changes. My role of observer may have taken precedence over my role as child psychotherapist. At such times I was experiencing the different demands of observer and researcher, which impacted upon my practical role as a staff member.

Burgess (1984), writes that 'research roles are constantly negotiated and renegotiated with different informants throughout a research project'(p.85). In my research, I worked as a child psychotherapist contributing to the work for the first three months, for the next three months I was writing the research proposal and thinking about the research while continuing in my role. For the next six months I collected data and functioned as a participant observer, both continuing to work as a child psychotherapist and attempting (as Burgess puts it, 1984 p.92) to 'cause as little disruption as possible in the social situation'.

Skogstad and Hinshelwood (2000, p.17), state that psychoanalytic practice involves a very specific skill- that of the participant observer.

> In the clinical setting, a psychoanalytic participant observation has five aspects: a way of observing with 'evenly hovering attention', and without premature judgment; the careful employment of the observer's subjective experience (sharpened as much as possible by personal psychoanalysis); the capacity to reflect and think about the experience as a whole; the recognition of the unconscious dimension; and the formulation of interpretations which afford a means of verifying (or falsifying) the conclusions the psychoanalyst has arrived at through this process. While […] interpretation belongs only to the clinical setting, all the others can be transferred to psychoanalytic research outside the clinical setting. (p.17)

The authors' comparative method of observing organisations is close to field-work in anthropology and sociology. The psychoanalytic framework has

much in common with infant observation. The authors conclude that while theoretical preconceptions are "inevitable", they can be seen as forming a "sort of spyglass". (Ibid., p.25)

The research claims of this method of observation must be "modest and take the form of descriptive work that gives rise to hypotheses for further work' (Ibid., p.25). In this study, I formulate ideas and hypotheses based on what I observed and I acknowledge there are limits to interpretation and degrees of certainty. However, becoming a participant observer enabled me to:

> …obtain accounts of situations in the participant's own language which gives access to the concepts that are used in everyday life […] Researchers can utilize their observations together with their theoretical insights to make seemingly irrational or paradoxical behaviour comprehensible to those within and beyond the situation that is studied. (Burgess: 1984, p. 79)

I am confident that the research has relevance and applies to other child psychotherapists engaged in outreach work.

Data collection and Triangulation

I decided that the sorts of data that would be useful in studying the institution were interviews with the staff group, observations and a reflexive journal. The journal included attention to my own experience, which in itself is a form of observation, but with a dimension of counter-transference derived from my child psychotherapy training. Data collection began 4 months into my work at the Children's Centre and ended a further 6 months later. Earlier observations contributed to my understanding of the situation, even though I did not begin to document them until my research formally started. My training in infant observation and child psychotherapy required that I kept detailed notes, so the research journal was a natural extension of this.

Following on from carrying out the interviews with the staff group and transcribing them, I decided in supervision that it would be important, in

terms of mapping the service and hearing more about the history of the service, to ask to interview my predecessor. This had not been included in the original ideas surrounding data collection. However it felt as though there was a gap in the study without her contribution, since she was so often referred to by the staff group in their interviews and she had been a part of the work for so long.

The use of a journal, alongside the observational material and the interview data attempted to 'map out, or explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint' (Cohen and Manion: 2007, p.254) Triangulation has been criticised for assuming that sets of data derived from different sources can be compared and considered as equivalent in their relevance to answering research questions. Denzin (1978) suggests the following points to clarify the use of triangulation in research:

> Methods should be combined with a 'checks and balances' approach so that threats to internal and external validity are reduced as much as possible. The theoretical relevance of each method must be considered as well as the implications of combining methods which at first may appear contradictory. (1978, p.303)

Researchers should continually reflect on their methods, being ready to develop or alter them in the light of developments in the field and emerging data.

Evolution of the research

The decision to interview my predecessor took place after my original supervisor died. My first supervisor, Cathy Urwin, had been involved in an earlier manifestation of the Therapeutic Playgroup and had played a key role in the development of child psychotherapy outreach services for young children and their families, during the 1990s. Inevitably, when she died and my new supervisor began to work with me on the study, some aspects of the research developed in different directions.

One development was an increased focus on psychoanalytic organizational concepts. These concepts were new to me and became important in terms

of understanding the data. At the start of my research, I had originally planned to ask a child psychotherapy colleague to conduct an interview with me, as the 'child psychotherapy' member of the staff group. However, having been a member of the team for such a short period meant that the interview felt limited in terms of providing a history to the playgroup. In contrast to this, the interview with my predecessor enabled further complex data to be gathered focusing on the evolution of the role of the child psychotherapist in particular.

In summary, (the interview with myself as the interviewee) shared similarities with other interviews in terms of describing the difficulties inherent in the work, such as families 'dropping out', and when families struggled to engage in what was on offer. I provided an example of an intervention with a family who at the point of referral were invested in their two year old receiving a diagnosis of ADHD (attention deficit hyperactivity disorder). It emerged over time that there had been domestic violence in the family and the child was presenting as vigilant of his mother within the playgroup. Moving from wanting a diagnosis to being able to think about the child's experience of his early family life meant that significant changes took place in the mother-infant relationship.[3] I was unable to provide a clear narrative relating to the history of the Therapeutic Playgroup in the way that other members of staff were able to.

I found the interview experience an uncomfortable shift from my role as interviewer to interviewee. I sought to clarify my discomfort and whether it was linked to a fear of exposure and the anxieties I felt about my role becoming focused in the interview. I came to realise that participants had tended to avoid talking about me with reference to questions about child psychotherapy. This suggested that my predecessor emerged as the appropriate representative of the role. Despite discussing the interview in supervision, and feeling convinced that it was appropriate to use my predecessor's interview and not mine within the study, I later reflected that my reaction to my own interview could be

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[3] Please see Appendix IV for an extract from my interview.

understood as my experiencing the doubt and uncertainty of the value in what was remaining in the playgroup, after the departure of so many valued staff members. It was not possible to understand this at the time, possibly because of how immersed I was in the work. As Armstrong, (2007, p.200) comments, possible dynamics can be missed, because of being unable to 'make use of team countertransference.'

If I were to repeat the study I would do more to investigate the outer boundary of the institution. For example, interviewing the senior management group of the broader institution would hopefully have provided insight into the relationship between the playgroup and the broader objectives of the institution. As it was, I existed on the 'inside' of the institution, within the playgroup and as a 'visiting' member of staff, both temporary and working in a CAMHS clinic outside of my playgroup work.

Interview bias

The effect that I may have had as the interviewer in terms of the validity and reliability of the data requires reflection. As Fielding writes: "Active commitment to a particular perspective during the interview certainly affects the results. On the other hand, it is easy to overstate the problem of interviewer bias." (Fielding: 1993, p.147)

Fielding (1993, p.147), cites Merton and Kendall (1946) in managing the issues of interviewer bias:

> Guidance and direction from the interviewer should be at a minimum.
> The subject's definition of the situation should find full and specific expression.
> The interview should bring out the value-laden implications of response. (p.541)

The participants knew me outside of my researcher role and had varied amounts of experience of working with me. This meant that they had ideas about me based on my work with families and as a facilitator of meetings; for

some participants this would mean they saw me as being in a position of power. Perhaps wanting to please me by saying the 'right answer' impacted on some interviews. In relation to other participants, I was relatively junior and limited in experience. This might have led to thoughts about me not being a 'full' member of the team, since I was working both on a temporary basis and in training. It is possible that this led to franker responses from these participants who felt that I would be leaving before long, and they would no longer be involved with my research.

When I introduced the participants to the research, I explained that I was interested in learning about how the team had worked together as well as what the contribution of the child psychotherapist to this work was. This was necessary in order to obtain informed consent from participants. However, introducing these matters inevitably created speculative ideas about what it was I wanted to hear; perhaps they expected me to want to hear how successful the team was and how valued child psychotherapy was.

In order to help participants move beyond this stance, the question surrounding the role of the child psychotherapist was asked at a late stage in the interview schedule. It was anticipated that this would be at a point in the interview when the participant had settled in to speaking about their own work and had moved beyond a shallow or idealised way of speaking. The question was worded as "how do you understand the work that a child psychotherapist does within the team?" The aim was to invite the participant to consider changes in understanding over time and to think about the professional role beyond a specific individual.

I had discussed in supervision whether I should reference my predecessor, since most staff members had significant experiences of having worked with her. We decided that my predecessor could be used as a prompt if the participant struggled to respond to the question and an additional aspect to the question would help to clarify the question, taking the form of "Do you

feel the work that a child psychotherapist does in this context differs from other contributors to the work?" (Please see Appendix III)

Being aware of the different ways I might have been related to and maintaining a reflective stance in the face of this has been an important aspect of data analysis. This has meant asking myself difficult questions about how my perceived competence or my capacities as a member of the team, both in terms of being a disappointment or as a valued team member, might have impacted on the responses given in interviews. By the time I had obtained ethical approval and was carrying out interviews I had only a few months remaining of my contract and it was not known who would replace me. While I can't 'know' how my role as interviewer affected the participants' responses, by querying and subjecting myself to self-scrutiny regarding the possible effects, I have been able to take a realistic and active approach to the difficulties of the method.

My concerns that it would be difficult for the participants to speak critically about the work of the child psychotherapist were challenged on a number of occasions when participants expressed ambivalence, confusion and uncertainty about the role. There were also some positive and unambiguous responses. However, the range of ideas expressed meant that it was probable that I was not being told whatever it was that they may have thought I wanted to hear.

Possibly, had the interviews been carried out by an independent interviewer, there would have been more honest responses from the participants. In one sense, the interviews were about me/child psychotherapy, and were being conducted by me. The interviewees might have been less cautious with an independent interviewer because there would have been less at stake, whereas they may have more complex feelings with me. Schwartz et al (1979), suggests, '…the participant observer through his familiarity with the subjects and his skill in interacting with them, may be able to handle the

interview situation better than an outsider" (p.42).

Fielding (1993) has suggested that the assumption that language is a good indicator of thought and action needs challenging. "Expressed attitude is a problematic indicator of what people have done, or will do". (p.148) Equally Mason (1996) has suggested that the interview method is "heavily dependent on people's capacities to verbalise, interact, conceptualize and remember" (p.64). I was mindful of how the participants were aware of job losses and possible changes to their place of work and was aware of how this might have affected the way in which they spoke about their work.

There was evidence of attempts to communicate the effectiveness of the playgroup in a way that felt defensive, protective of the work and at times reminiscent of a job interview. Being aware of my true role and in relation to my perceived role to the participants and acknowledging that I was not a neutral data collector, were important issues to discuss in supervision.

Sensitive interviewing

The context in which this piece of research was carried out coincided with a period of organisational crisis, in which members of the team were made to re-apply for their jobs and were faced with redundancies. I was concerned about the experience the interviewers might have in talking about the work in this context. When the original proposal was submitted there were no threats to the future of the institution, nor were there looming redundancies. I felt the significance of the changes meant that this needed to be included in the study and participants should be given the opportunity to speak about their experience of this. The interview schedule was redrafted to include the question "what do you feel is important for me to know about the current changes and uncertainties about the future of the institution?"

Margareta Hyden (2008) writes about the importance of being aware of

one's own relationship to the interviewee, and she warns against making generalisations about what participants might be sensitive to.

> Cultural, contextual circumstances and the personal views, power and space, held by the people involved are all factors in determining what a sensitive topic is. As a researcher dealing with sensitive topics you are always at risk of your interviewees positioning you as superior to them. (p.124)

She highlights the need to be aware of the interviewee talking about issues that may feel shameful, or issues that might be "rated culturally low, or events that have left them vulnerable" (p.127). One consequence of this is a "risk of meeting resistance from an interviewee that is manifested in various ways of avoidance" (Ibid., p.127). She states that this limits what can be obtained from the research if one is not aware of the resistances one may be faced with within an interview.

A distinction is made by Hyden, in terms of an event that involves sensitive experiences and a sensitive topic. "Talk about a traumatic experience has the potential to pose a threat and even has the potential to re-traumatize but such talk can just as well have the potential to heal" (p.128). Sensitive topics "basically have to do with relational circumstances". In describing the process of interviewing, she describes the concepts of 'answer' and 'question' as "part of a circular process, with my informants and I trying to make continuing sense of what we were talking about" (Ibid.,p128).

She describes how she initially perceived herself to be in a subordinate position in relation to other "informants' upon whom she was dependent for the detail of their experiences; in this case, experiences of domestic violence. Yet she came to understand that she, as a researcher, was regarded as holding a culturally highly valued position.

This work helped me to be aware of the possibility of making false assumptions about the experiences of the participants. I realised that I

tended to imagine that some participants considered me to be a junior colleague. This might have been a false assumption and inaccurate for a number of reasons. It also helped me to think about the importance of remaining open to the possible range of responses and feelings stirred up by the experience of talking about one's work and role during a time of organisational change; an experience that might have stirred up different forms of anxiety, defensiveness or a wish to please or demonstrate one's competence.

I wanted participants to feel they could say as much or as little as they wanted with reference to the changes taking place. While I was aware that talking about one's job during a period of cuts might feel 'too close' to the experience of attending a job interview, I wanted to remain open to the possibility that to talk about the situation might be experienced as a relief or a welcome opportunity to air difficult feelings.

Thematic analysis

The research participants were a diverse group of individuals with a range of trainings, levels of education, work experience and cultural heritages. To take this into account required an appropriate method of data analysis that would provide an opportunity for the staff group to articulate the range of voices. Thematic Analysis methodology was chosen for its emphasis on allowing the data, and eventual theories to be developed hence reflecting the concerns of the participants

Boyatzis (1998) has observed that thematic analysis is "not another qualitative method but a process that can be used with most, if not all, qualitative methods" (p.4). Thematic analysis is a method for identifying, analysing, and reporting patterns or themes within data. It organises and describes a data set in detail. It also often goes further than this and interprets various aspects of the research topic. (Boyatzis,1998, p.4).

Braun and Clarke (2006, p.78) state that although thematic analysis is widely used, "There is no clear agreement about what thematic analysis is and how you go about doing it" (p.78) and because of this, clarity regarding how the data is analyzed is important. The authors have responded to the criticisms made about the flexibility of thematic analysis, "Through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data" (p.78). Braun and Clarke state that they are not trying to limit the flexibility of the methodology, "however, an absence of clear and concise guidelines around thematic analysis means that the 'anything goes' critique of qualitative research may well apply in some instances" (p.78).

The thematic analysis of the data allows the study to grow in an organic way towards the development of a theory or model related to the research questions formulated at the outset. In thematic analysis the approach is to start with a general research question, which will become more focused as the study progresses. This enables the researcher to maintain his/her intimate relationship with the data whilst not becoming overwhelmed by it during theory generation. This approach supported the development of the research. It was necessary to adapt from the original research question to include the changes taking place in the organisation by the time the interviews took place.

Braun and Clarke (2006) conclude that thematic analysis can be a "method which works both to reflect reality, and to unpick or unravel the surface of 'reality.'" (p.81)

Data analysis: an example

The analysis of the data in my research took the form of three main stages which overlapped to some degree: the free line-by-line coding of the findings of primary themes; the organisation of these 'free codes' into related areas to

construct 'descriptive' themes; and the development of 'analytical' themes. Here is an extract of data, with three different stages of analysis applied to it.

> Interviewer: I'd be interested to hear if you do have a sense of what made a piece of work with a family successful, if there was something you felt you could, er, identify, that tended to help with engagement, or thinking, or if it's hard to generalize?
>
> Participant: (10 second silence) I'm not sure that I really know. Except, I suppose there's something about, that I think is helpful anyway, you know with any work really, is trying just to start where the family was, in terms of what their understanding was, yeah, their perceptions of the problem, which might be very different from how I might have, um, how on hearing it, how I might have thought about it. So, I might come up with a formulation for me and they might have a different idea, and in some ways, I suppose, it was about me moving more, closer to where they were, and them also maybe moving closer to where I might be.

First stage: line by line coding:

The underlining relates to phrases, expressions or words that I thought might have some meaning or relevance or prevalence, based on a first attempt at line by line identifying of themes. The bold writing relates to primary themes.

> (10 second silence) **Reflective silence** I'm not sure that I really know. **Uncertainty.** Except, I suppose there's something about, that I think is helpful anyway, you know with any work really, **General clinical approach as opposed to specific outreach approach** is trying just to start where the family was, **Family understanding of situation** in terms of what their understanding was, yeah, their perceptions of the problem, which might be very different from how I might have, **difference in understanding the difficulty** um, how on hearing it, how I might have thought about it **starting point/engagement.** So, I

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might come up with a <u>formulation for me</u> and they might have a different idea, **differences in understanding what the difficulty is** and in some ways, I suppose, it was about me <u>moving more, closer to where they were, and them also maybe moving closer to where I might be</u> **changing/shifting perspectives both clinician and family.**

<u>Second stage: Descriptive themes and subthemes</u>

Different stages in the work: Starting point: 'start where the family is'
Differences in understanding: clinician versus family understanding
Reaching a formulation: drawing on theoretical framework, drawing on experience
Different stages in the work: Middle/end stage: Changes and shifts: 'moving closer to where they are' 'moving closer to where I might be':
Reaching a formulation: 'moving closer to where they are' 'moving closer to where I might be': Flexibility, willingness to change understanding
Universal approach to work versus specific approach to playgroup

<u>Third stage: Analytic themes</u>

<u>What is the problem?</u>

How the clinician understands the problem
'How I thought about it'

How the family understands the problem:
'What their understanding is'

<u>Changing perceptions: Moving closer</u>

Clinician moving closer: to where they are

Family moving closer: to where I might be

This example of a data extract reflects an aspect of the interesting complexities that I found in the data analysis.

Rather than seeing the research as a process of discovering the objective truth of the social world, the research is considered to be a contextual process that is engaged in establishing one account of many possible truths. Anderson (1993) suggests that researchers from an ethnic majority background working with respondents from ethnic minorities will always have a partial, incomplete and distorted picture of their participants' lives, but that this does not make the picture necessarily less 'true' than accounts elicited by a researcher from the same ethnic group as the respondents. I was mindful of this in my interviews with members of the staff group for whom English was not their first language and with members of the staff group who were a part of a specific ethnic and/or religious heritage.

Reliability and validity

Despite not using grounded theory as my methodology, grounded theory methodologists Strauss & Corbin (1998) suggest validation methods appropriate for my study. They maintain that, because the role of the researcher is openly acknowledged within the process of data generation, traditional approaches to validation checks including respondent validation are less appropriate. Instead they suggest the following methods:

An Audit Trail: To write the report in a manner that highlights its conceptual twists and turns as it progresses from beginning to end.

Trustworthiness of the theory: are the interpretations and theories plausible in their relationship with the data?

> The inclusion of negative case analysis to provide a degree of falsification of theory.
>
> Researcher reflexivity: Is there enough evidence that the researcher has promoted personal reflexivity and epistemological reflexivity as the study has progressed? (p.273)

These ideas and methods remain relevant to validating the research in the following respects.

1. A reflexive journal was maintained throughout. This detailed the logistics of the study and then methodological considerations as they occurred, together with reflections on my own thoughts and experiences of carrying out the research.

One issue that arose in the data collection was the possible over-reliance on the material from the interview with my predecessor. I wanted to clarify that I did not give more attention or validity to her material than to the material obtained from other participants. This is because we are both members of the same profession and she was formerly my colleague. To manage this, I thought about it at length and discussed it in supervision. I considered it important to consider the data available from other sources in relation to her interview.

2. The observations I made during playgroups were written up soon afterwards, usually within 12 hours. My observation skills have developed throughout the process of my training, partly as a result of my having written up a baby observation on a weekly basis for 2 years, and having recorded on a weekly basis a year long young child observation. In addition to this, an important part of the clinical training is the writing up of process notes of psychotherapy sessions for supervision purposes.

While it is clear that 'objective' observation is not possible, there are ways of thinking about the potential credibility of the clinician-researchers account.

Fielding, when considering validation of ethnography, writes:

> The participating observer is involved, not detached. Understanding is derived from experience. Beginning to share in the member's world enables one to gain access to one's own personal experience […] Followers of the method have therefore pursued a test of congruence or principle of verifiability. The idea is that in any natural setting there are norms or rules of action in which members are competent. Understanding on the part of the observer is achieved when the observer learns the rules. (1993,p.164)

Acknowledging my role as both clinician and researcher and thinking about this within my supervision, in terms of providing a different perspective to the observational material, helped to clarify the issues that arose in the analysis of data.

I believe that I have gained meaningful knowledge about the institution through observation. This could not have been generated from interviews alone. This is because not all "knowledge is articulable, recountable or constructible in an interview" (Mason, 1996, p.85). I have included information within the observations about my own emotional responses to what I had experienced.

Ethics and ethical approval and considerations

Before conducting the research, I submitted a proposal to the University of East London ethics committee and to the relevant Local Authority ethics committee. I received written approval from both committees.

To ensure that the data remained confidential and anonymous I transferred the interview recordings on to an encrypted memory stick. The memory stick remained locked in a work filing cabinet.

When writing the analysis of findings it was necessary to find a balance between protecting the anonymity and confidentiality of the participants and

being able to identify whether the participant was a professional or a member of the family support team. I took measures to provide essential information regarding the role of the participant, such as 'professional staff member 1', and whether the staff member had relevant managerial responsibility. No further detail was provided, apart from gender when this was unavoidable.

I also made the decision not to disclose the name of the institution. This was done in order as far as possible to preserve the anonymity of the institution

Reflections on research methods

There were a number of methodological considerations which required addressing as my study progressed. Arguably, the most significant of these were the threats to the closure of the Centre and the changes in staffing. If I had not considered these matters the original proposal would not have provided a realistic understanding of what was happening in the institution. Therefore the study had to be adapted to include and think about what was happening in the institution during the period of data collection.

Research methodology and the chosen research method are both influenced by the epistemological position of the researcher, specifically: what ideas and beliefs about knowledge does s/he have? Willig (2001) suggests that there are three important epistemological questions to ask at the beginning of a research project:

1) What kind of knowledge does the methodology aim to produce?
2) What kinds of assumptions does the methodology make about the world?
3) How does the methodology conceptualise the role of the researcher in the research process? (p.44)

The development of the research proposal and a consultation period with a

supervisor helped the researcher to carefully consider these issues. I believe that the following position was reached:

1) The research was concerned with helping the participants to articulate their experiences of working in a specific setting. It follows that the type of knowledge produced was based upon the participants' own reflections upon their work and their working relationships. The research was primarily interested in describing what was said. However, it was important to think about how the participants had arrived at their opinions, so an element of explanation was required. Willig (2001) suggests that it is vital that both a subjective account and an objective description of phenomena are produced in any attempt to "capture the lived experience of the participants" (Ibid., p.44).

2) The data set that is generated by the research is not simply collected from the participants by the researcher. It is the outcome of the engagement between both researcher and participant being used to produce a meaningful joint outcome.

I was often surprised by the responses from participants either because of how candid I thought they were or because of how they used the forum of the interview.

For some participants the interview was an opportunity to showcase their work; for others it was a chance to air complaints and share criticisms. I was struck by how their distance from work enabled participants to reflect on how they work. For many who were caught up in the process of reapplying for jobs and waiting to see the outcomes of institutional re-organisation, the interviews appeared to be a different kind of experience. There were signs that it was harder for these participants to describe their work and I was aware of trying to find a balance between, on the one hand, opening up

discussion and exchanging thoughts and on the other, allowing their guardedness or caution to remain protected.

In this kind of study, which is based on triangulating several sources of evidence, an interpretation of the meaning of the findings is developed, to make a conceptualised account from the many observed and reported aspects of the work. An analysis needs to be grounded and evidenced in this detail, but it also develops its own meaning and shape. This is what I aim to demonstrate in the Chapters which follow.

Chapter 4

Analysis of findings

Introduction

This chapter attempts to capture and explore a range of themes that were evident from the interview data and field notes, as well as my own experience of working in the institution. Attention is given to the spectrum of ideas about how the institution functioned, the role of the child psychotherapist and whether the agreed aims of the work were achieved.

Part 1:

The Therapeutic Playgroup within the broader institutional setting

What were the purposes of the institution?

A distinction must be made between some of the formal objectives of the broader institution, the Healthy Living Centre, as compared with its achievements. It is necessary to look at what was really prioritized and what could actually be done with the resources available. My work was largely in the Therapeutic Playgroup, within the institution, I learned what I could about the broader institution from documentation and literature about it.

Miller and Rice's (1967) framework for exploring the specific purposes of an institution, or the primary tasks of an institution can be applied to the official policy statement of the institution:

> Our mission is to help create a cohesive, healthy, successful and vibrant community, and to remove the label 'deprived' from the local community. (Source not attributed because of anonymity)

There is a focus on the accessibility of the institution:

> The Centre is committed to continual outreach by knocking on doors as well as making contact through GP surgeries, local schools and other venues. Also, a large percentage of the staff team is recruited locally, meaning that they understand the issues that the community faces and

act as positive role models. (Source not attributed because of anonymity)

There is also a commitment to integrated services, meaning that services work together in a coordinated way with families. The term 'progression pathways' is used to illustrate the aims of the institution in terms of moving people forwards. This is described as a model that is specific to the institution:

> At the heart of the model is the phrase "assume it's possible". This encapsulates a determination to ensure that everyone who engages with the Centre is enabled to fulfill their full potential. Key to this is the way Centre staff support individuals, both formally and informally, over many years. The end result is people achieving changes in their lives and circumstances that they never dreamed were possible when they first arrived. (Source not attributed for anonymity purposes)

This statement reveals the ambitious nature of the institution's objectives. The project depended on the coming together of several different sources of vision and energy. The broader institution was an early example of social entrepreneurship, committed to community energisation and self-expression through the arts and many forms of initiative. Sure Start, at its optimistic, visionary beginning, was one of the most invested initiatives of New Labour. In terms of the Therapeutic Playgroup, the ideas of what CAMHS could do in a community like this emerged from a small number of clinicians, and how important it was to leave the confines of the clinic, and to go and find the people that needed help. Another idea embedded in the possibilities of multi-professional work is that the separate disciplines can do more if they get out of their specialist silos, and also that people closer to the community (Family Support Workers) could be indispensable to this work because of their 'local knowledge' (Geertz, 1983).

The primary tasks can be defined through the coming together of these different strands. The broadest, from the institution in its entirety, was that of community development and integration, achieved in a democratic way from an ethical commitment and with a religious connection. A second primary task, located in the Healthy Living Centre, was the specific commitment to families and children, especially very young children, who would attend the various services offered

by the Children's Centre. Then, further down the line, there was a community mental health dimension to this work, with the Therapeutic Playgroup, and within it a CAMHS 'outdoor' component as a key instrument for furthering this, but in ways completely consistent with the community focus of the larger project. The aims of the Therapeutic Playgroup also tie in with the 'overarching aims' of the history of the early toddler and mother-infant playgroups, described by Hoxter, (1981) and by Zaphiriou-Woods, as a commitment to 'toddler development' (2012, p. 350).

This can all be perceived as one broad 'primary task', from the larger community integration or improvement strategy of the broader institution, and then interpreted in more specific ways by the Children's Centre and the Therapeutic Playgroup activity within it.

From my own experience of the playgroup, there was a degree of cross-over between formal and latent objectives as set out in the mission statement, which is the statement for the Healthy Living Centre. The Therapeutic Playgroup shares the same goals or tasks as the Centre in the sense that it was in fact a particular or specialised version of these central goals. The playgroup needed to engage the client base, the child and the important adults in the child's life. The institution employed staff who were paid to encourage families to take up community, educational and learning opportunities. It was attempting to be a community based hub and was located in the heart of several large housing estates, within which there was overcrowding, poverty and high rates of depression and other mental health difficulties.

The local general practitioner doctors informed the staff, at weekly meetings, that there was an extremely high rate of patients requesting anti-depressants to combat unemployment and cramped living conditions. According to my child psychotherapist predecessor local doctors would talk about families who presented as chronically entrenched in their difficulties, "They just sort of said, 'look, this is just going on and on and on'". The latent objective of the institution was to find innovative ways to create some kind of a shift in the predicament of

chronically stuck families and to improve upon the revolving door quality of care.

These families were contacted by the staff and encouraged to attend different in-house services within the institution. Staff were mindful that many of the depressed or isolated patients attending GP surgeries had children, and spoke about their awareness that children may become lost in the attempt to help the adult presenting with depression or other mental health difficulties.   One existential primary task, that is the primary task in its actual practice, was therefore an attempt to bring whole families into contact with the institution, including their young children.

The interventions made by the institution aimed to provide comprehensive family support, with the challenge being to safeguard children, as well as support the emotional development and early education experience of children. This was assessed by home visiting services, being health visitors, family support workers, and in house specialist services, including the Therapeutic Playgroup.

The playgroup functioned as one of many services available for families within the broader institution. These families had been identified by the Family Support Team as likely to benefit from an informal sociable and welcoming group environment. It was considered desirable to join up isolated families in order to create a 'community', and also further to engage with services and professionals.

> I thought my role was to, to carry on supporting them, but also to sell this idea of this being a group that would be really good for them to come to and would have benefits for them, and I think they were, they were quite happy with that. (family support worker 1)

The aim of an intervention within the playgroup was to secure children and parents' progress and development via a range of professional support, to gain the trust of parents and to be able to work with client populations who would not ordinarily attend an appointment-based clinic. There was a particular need to reach the Bangladeshi and Somali communities, as well as to encourage

fathers within these communities to be involved within the institution. This was reflected in the playgroup staffing; all of the Family Support Workers were either from the Bangladeshi or Somali communities.

Many of the families from these communities who attended the institution did not speak English. This was one barrier to engagement that was eased by the language skills of the staff. Another barrier which needed to be overcome was the inability of parents to speak to professionals from children's services and suspicion about what it meant to speak to these professionals. Parents were encouraged to attend English lessons and to become involved in a volunteering scheme within the institution, or be helped to find paid employment.

The normative primary task of the broader institution, (Lawrence, 1985) in accordance with the mission statement and publicized objectives of the institution, was to enable isolated, potentially vulnerable adults to become part of a local community and to spend time outside of the immediate family or home. The phenomenal primary task, not openly acknowledged, was to establish community integration away from a specific ethnic or cultural identity and into a broader community of people from different minorities and backgrounds, who, because they spoke English, would have less difficulty in finding employment and accessing other services.

The Therapeutic Playgroup: tasks and roles.

Within the Therapeutic Playgroup team there was a broad and varied range of understandings about tasks, activities and roles in relation to the Therapeutic Playgroup.

One of the tasks identified by the Family Support Team was to identify suitable referrals for the playgroup, based on other non-targeted stay and play sessions held at the Centre. This was in addition to referrals from GP's and Health Visitors. Often, this meant physically escorting families to the playgroup for the first visit.

A lot of families, unless it's right on their doorstep they're reluctant to come out, but unless you escort them here, which I do, they're quite happy, and they can see where it is, and it's quite a nice place, and once they see their child enjoying it they're happy to come back. (family support worker 3)

One family support staff member stated that she alone identified the specific objectives she wanted a family to achieve, as opposed to working collaboratively with a family. For example, this might include helping a child to be toilet trained or helping a parent into employment. This suggests, in line with Anning et al's work (2007) that for this staff member the degree of personal investment and commitment in the work is significant. She described a piece of work with a family that involved liaison and work with legal services, housing, social care, as well as attending hospital and doctor appointments with a parent: "I wanted that goal actually… I targeted the goal and I needed it to be achieved for the family to go somewhere". (family support worker 1) This also links to Urwin's (2003) view that personal commitment to the work is vital to developing services.

Other staff expressed a commitment and an investment at a personal level as vital components in establishing the aims of the work. Having identified what she considers to be the aims of the work, family support worker 1 has a formulation of how she will know whether a goal has or hasn't been achieved. In the case she provides in the interview, the goal is for two children to be returned to the care of a mother who had experienced severe depression. There is no sense of ambivalence or negativity expressed in relation to the mother and children, which suggests that what may have contributed to her investment in the work was a sense of being in the 'right', or doing the 'right' thing by the family. Acknowledging feelings of ambivalence in this context might make fulfilling the primary task of supporting families a more complex task; for example, what if it was felt that a family did not want to find paid work, or was not grateful for the support on offer?

For some members of the team, ambivalent feelings in relation to the families

are not expressed and the formal objectives of helping and supporting families remain at the forefront of their approach to the work, according to their interviews.

Most of the professional staff group expressed the opinion that, at the point of referral, work was needed to alter and adapt the parents' ideas about what the individual staff member could provide. The majority of professional staff described this as being less of a personal aim or goal, and more a part of a broader approach to the work, associated with a theoretical framework or professional underpinning.

> It's trying to formulate with them some wider idea of what's going on so they, the idea would be that they get more of an ability to reflect on themselves and step back and be their own therapist a bit. (professional staff member 2)

For this professional staff member, the aims of the work were about helping families to see that "even in a very stuck situation, there might be things that they do differently". She felt that part of the reason she was recruited was because of her "honesty" in her presentation of clinical work at the job interview. She had presented a complex case for which she "did something very small, that might have a little effect".

The spectrum of ambition ranged from a sense of personal investment in an ambitious and life-changing goal, such as re-housing or even re-constituting a family, to feeling that doing something very small might be the most realistic way of shifting a difficulty in family life. This variation reflects the range of approaches to the aims of the work but it also conveys the degree of hope and optimism required to engage with this type of work.

Professional staff felt that the starting point of the newly engaged parent was often unrealistic and passive. The expectation was to "make them better, in a not very thought out way". (professional staff member 3) Or, "…often what people come wanting is for you to change their husband, or partner, or their mum, you know, so it's sort of shifting that back to them" (professional staff

member 4). Two members of the professional staff group use the term "magic" to convey what families would like to be able to receive. A process of demystifying the professional approach is described:

> I definitely begin by saying what I can offer and that it's not a sort of magic thing, that it's going to be sort of maybe a bit of a map to find a way forward and that they might hopefully feel less overwhelmed by the end of it, um and more able to cope um, and quite often people come and say that they don't really know what they want, but they're feeling very stuck. (professional staff member 2)

Professional staff member 1 identifies a similar wish families express, a hope that something "magical" might be delivered by the professional. She suggests that part of the work is "about getting parents involved, is about talking about parents' role in communication"; again, a reference to helping parents to take on a more active role, whether it is in terms of the relationship with their child or, as one professional staff member articulates, in terms of inviting and including the father/partner to the group. "It was interesting because her husband came and he was really, he did not want to be there at all, and that really shifted". Another way of describing a task of the work is "not magic" but to "give people a chance to talk so that they could work it out for themselves". (professional staff member 3) The work involved in helping parents to change their perception that the professionals have the answers of the solutions, to helping parents to recognize their own role or contribution to their situation might be identified as an existential primary task (Lawrence, 1985). This role might also suggest some unconscious phenomenal components, a wish from the professional to not fulfill a fantasy of being a 'magical' parental figure, one who will inevitably disappoint and fail.

A number of members of the professional staff group considered the allocation of responsibility within the service. This was understood in a number of ways, one of which was the skills required to recognise and deal with impasse.

> I think sometimes what's happened is the family support team have referred people they feel very stuck with and they feel overwhelmed with this person, so they refer them to me and I become the one who's stuck, (laughs), so that's yeah, not so successful, um, but I think that's sort of

more appropriate that I'm stuck with them, than the family support worker, in terms of training and all the rest of it. (professional staff member 2)

The experience of impasse in the work can be thought about in different ways, for example the referral might be made to 'specialist services' because the staff member feels s(he) can go no further with the family which still needs more support. Staff members also need the capacity to bear feeling useless or helpless, or to remain thinking through an impasse.

The professional training provides a way of distributing complex cases; the more stuck, the likelier the referral to specialist help. Although this maybe considered 'appropriate', there is also some thinking about the way in which 'stuckness' is moved around the staff group. Interestingly, this does not necessarily lead to an 'un-sticking' of the problem or difficulty, but to relieving the family support team and enabling their work to continue. They can now engage new families and continue the flow of referrals into the playgroup and in this way continue to meet one of the primary tasks of the institution, an ongoing influx of new families attending services, alongside the departure of other families who no longer require the playgroup.

For one member of the professional staff group, raising as opposed to restricting the parents' expectations of what was on offer was part of the work. For some families, the setting of the Children's Centre meant that something inferior was being offered.

> So, sometimes there is sort of scenario with people thinking that you've got something, this did happen actually, people thinking, that what I was doing was not the real work, so people were aware that, erm and on several occasions I had to say yes, they do it up there, but that's, I'm part of them, and what I do here with you is yours, and it's not different, or better, than what they do up there. (professional staff member 1)

The distinction between "up there" and "here with you" is valuable in understanding some families' perception of a professional being in close proximity and that this somehow made parts of the service less valued or

inferior. The significance of being able to convey "I'm part of them", meaning the "up there" service, enabled the role within the Therapeutic Playgroup to gain value. This implies that it was sometimes important, in terms of engaging families, to be seen as professionally linked to an external team or institution.

The need to link to an external organisation is highlighted by Urwin (2000, p.391). She cites the "essential" link to the CAMHS Team of which she was a part, not only in terms of discussions about work, but also in terms of a "secure base" from which one could do this type of work. It also suggests some form of professional containment, or reduction in insecurity, through feeling linked to an external agency. In this way, the staff members' professional identity was not undermined by some families, or even by their own ideas about what it feels like to be "here with you" as opposed to "part of them". This could mean there is the need to adapt one's role, as Turner (1962) writes. For this member of staff, his/her role is a 'working compromise between the formalized role prescriptions and the more flexible operation of the role-taking process' (p.23)

The lack of a formal structure or appointment system in the playgroup is described by the majority of staff members as reducing families' anxieties about professional involvement and interventions. It is suggested that these anxieties are overcome because the professional is close at hand and visible. It is helpful when a formal appointment has not been made as this might be cancelled or not attended, leading to a case being closed before work has been started or finished. The structure of other services, such as CAMHS, mean that engaging with vulnerable families is much more difficult owing to protocols relating to missed appointments. This was raised by all members of the professional staff group.

> In a system where if you fail to attend on three occasions, you will now be discharged, regardless of the fact that we know that the child has some things that we know that we could help with. (professional staff member 1)

> …You can deliver quite high quality advice and support without it being formal and also the children playing, the parents have got out of the

house and they haven't had to trek halfway across the borough to keep an appointment, which they're anxious about anyway, so it's just that, that business of having everything in one place. (professional staff member 4)

Since not all specialist work can be done without some formal arrangement and referral, this leads to the question: how can it be determined who requires a formal referral, and for whom will this not be suitable? Through a gradual process of engagement, various examples of work were provided by the staff group that allowed for referrals to other clinics and involved the wider family in professional services as a result of the work starting in the playgroup.

One staff member describes her role as providing a benign link between the professionals and the families, attempting to persuade and reassure families that involvement with professional services does not automatically lead to child protection procedures or to contact with Social Care.

> People who are thinking if they are going to the CAMHS or counselling, thinking maybe Social Services will become involved, and take their children and this was the fear. I was the link between the health professional and the family support worker. The idea was to set up something where the family are comfortable to talk to the professionals. (family support worker 5)

It thus seems some families do not differentiate between any professional services and perceive all professionals as having an agenda associated with child protection.

A staff member highlights another aspect of her role, as a member of a specific community, reassuring the community about professional services.

> We were thinking 'oh, there are no Bengali people coming', so I was going to people's home and explaining these professionals are helping you, instead of taking, and you are the best person to look after your child. Years and years I was advocating this to the community'. (family support worker 1)

There was a general belief held by the entire staff group that certain

communities were better engaged with by staff members from the same community. I was not aware of any ideas around the possibility that it might be off-putting to be contacted by a member of one's community; for example because of reasons of confidentiality, or of being harshly judged. Loshak's (2003, p.53), consideration of the "unconscious assumption that cultural difference cannot be understood" is relevant in this context, because of the way families were thought about. Thinking that the 'front line' of staff ought to be Bangladeshi, so as to engage Bangladeshi families, was perhaps a rather narrow way of understanding and engaging a specific community, and yet it appeared to work in practice, in terms of numbers of families attending. However, it remains difficult to know what it was that specifically worked. Perhaps I was unaware of when it did not work, and families refused to engage with family support workers. Certainly, I feel one important and positive factor was the trust that the family support team had in the work of the professional staff in conveying to families that this was a service that could help.

The Therapeutic Playgroup model might be described as a creative adaptation of other forms of mother-infant therapeutic work, located in clinics and hospital settings. The playgroup has a commitment to a preventative function, without having to mobilise formal child protection proceedings and the threat of coercion. The method was therapeutic, not instructional - helping parents to see how children could be attended to, not telling them what to do. This is in keeping with the main integrative goals of the institution.

While the reassuring of parents about the agenda of professional services is seen as an important part of engaging the most vulnerable families, a further point is made about the potential lack of transparency regarding issues surrounding child protection and what is being observed within the playgroup.

> I'm not sure about this, but I think quite probably the parents don't realise that they are, (laughs) being assessed in the way they are. I mean, we make no secrets about the fact that we have meetings afterwards and from the meetings we you know, we often make suggestions to them that we'd like to make a referral wherever, but I think for them it's just a way

of getting out of the house, and of yes, doing things they wouldn't otherwise do, so I think that there may be unconscious benefits, except that they know that their child likes it here. (professional staff member 4)

There is clearly some ambiguity in the families' awareness and understanding of the level of intervention that was taking place. The belief that there "may be unconscious benefits" suggests that the families gain from the work, regardless of the lack of transparency. However, there is the suggestion that families would not be as willing to attend, or engage, if there was complete transparency from the staff group about the possibility that referrals might be and in fact were made to Social Care as a result of what was observed in the playgroup. One of the primary tasks of the organisation is to contain families' anxieties about what professionals are interested in and yet there may be some uncertainty regarding family and child protection assessment within the playgroup.

Stokes' work (1994, p.121) concerning the publicly "stated idea" has relevance here, as there may be some hidden conceptions at work. The level of 'what we say we do' provides reassurance for families who might feel guarded or anxious about contact with professionals. There are the levels of 'what we really believe we are doing', being the latent objectives, which in this case are observing and responding to families within a child protection framework. There is also 'what is actually going on," which in this example suggests a lack of transparency with regard to how families were discussed in team meetings.

During a staff meeting I recognised a risk of the therapeutic task of the playgroup, and the primary task of the playgroup, being pushed aside. I was describing an initial conversation with a mother and child from a traveller community. The mother had been describing to me some separation difficulties that the child was experiencing, such as wanting to sleep in her bed. I spoke in the meeting about what I had felt to be the mother's steering clear of discussing the child's father, and how I felt it was too soon to address this, but that I was thinking about where he was and what he thought about the situation. The response from the staff group was to think about their experience of the traveller

community and how there was often domestic violence and feelings of shame surrounding this. One member of staff said that she did not recognise the family name, and suggested that I telephone a phone number linked to Social Care, which enabled professionals working with families to enquire as to whether there was any social care involvement, such as child protection assessments.

It was all beginning to feel like a request to run a 'background check' on the family. Some staff members felt that this was a good idea. I was surprised by their response because I felt that it suggested a suspicion about families which mirrored one of the beliefs held by many families. This was that that professional services were interested in seeing things only through the filter of child protection. I said that there was nothing about my contact with the child and mother that had made me feel concerned about her ability to parent and protect him, and to make this enquiry at this stage would feel premature. (Source: Reflective Journal). The response was that it was 'better to know' than 'not to know'. It suggested an anxiety about missing something. In this example there was little sense of trust in the process of building a relationship with the parent that would allow for this sort of information to unfold.

I feel this example demonstrates the pressure to move the Therapeutic Playgroup 'off-task' but also about the value of recognising the value of Lawrence's (1985) elaboration of the concept of the primary task. I was able to act and make sure that the playgroup remained 'on task,' and I experienced this as an example of a 'normative task' (1985) becoming actualised in practice.

Britton's work (1981, p.170) on how the experience is "forcibly communicated at an unconscious level to the professional network" which is in danger of reacting with action rather than thinking" fitted with this experience. I spoke about this family in supervision and decided not to call the phone number at this stage.

I continued to meet with the family and I recall feeling a pressure to 'keep an eye' on risk and possible child protection issues in a way that I had not felt to be necessary in my initial contact with the family. While of course it is important to

keep risk at the forefront of one's mind, I felt that this was a slightly different experience. It was my anxiety that I must not miss any possible sign of risk that was proving unhelpful. I felt I was losing sight of other, potentially more important areas of communication. (Source: Reflective Journal). The team had projected an anxiety about risk into me and this had affected the contact I made with the family. This experience made me consider to what extent the staff group was increasingly preoccupied with picking up on risk which disguised the latent objective of surveillance.

One can understand and appreciate this approach in light of recent high profile child protection cases in which professionals were found to have delayed intervention and not 'seen' the risk. Serious case reviews, which seek to examine why professional services failed to protect children tend to reveal a lack of 'joined up working' and missed opportunities to notice neglect and abuse. While it is essential that staff within an institution working with potentially vulnerable children are able to identify risk and mobilise child protection procedures, the concern that I had about the response to this specific family was based around a preoccupation with risk in a compulsive, as opposed to a reflective way. This may have prevented engagement and might even have made risk less visible if the family were to 'drop out'. My concern was that this type of preoccupation could lead to a defensive professional blindness; looking for risk in a way that might not allow for really seeing.

Nikolas Rose (1989, p.1-4) examines what he calls 'engineers of the human soul'; experts who advise how people ought to think and act in relation to areas including parenting and family life. Rose argues that the rise of psychotherapeutic thinking which promises freedom, autonomy and fulfilment, is actually linked to the emergence of a new form of "political rationality".

> Parental conduct, motherhood, and child rearing can thus be regulated through family autonomy, through wishes and aspirations, and through the activation of individual guilt, personal anxiety and private disappointment And the almost inevitable misalignment between expectation, fantasy and actuality, fuels the search for help and guidance

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in the difficult task of producing normality, and powers the constant familial demand for the assistance of expertise. (1989, p.130)

While the work of the playgroup was, in my experience, not concerned with producing 'normality', Rose's model would say otherwise, it did aim to engage with families where for example there might be hidden domestic violence taking place. Bringing families into the institution where issues such as this were occurring, and where there might be insufficient understanding of the devastating impact on children, was one aspect of the work of the staff group. For example a Health Visitor might carry out an additional home visit, perhaps with a family support worker, to observe the interactions within a family if there were concerns about domestic violence. This was not about inducing guilt or anxiety but about sensitive and cautious concern for the safety and emotional development of children.

In one interview, a member of staff describes an incident involving a child with autism being hit by his father during the playgroup:

> Within the group structure the father was able to engage better with his son, but it was quite a complex situation with his relationship with his child and there was an incident where he actually hit the child in the group, so the social services had to be involved and the family had to be supported to be helped to recognise how things were escalating in terms of this child and understanding his behaviour and the disruptiveness that his behaviour brought to the family […], and for social services to be involved sort of brought the family together around what was happening and he became much more pro-active about how to move forward with the relationship with the child, how to talk to the school and the transition. (family support worker 5)

This vignette of work with a family suggests that the disturbance in the relationship between father and son was brought to the group in such a way that action had to be taken from a child protection perspective. Prior to this, there is a sense that the father was not sufficiently in touch with the impact that his son's autism may be having on him and the family. This suggests that for some families, there was a need for an increase in anxiety, or a lack of sufficient containment before issues can be addressed and thought about; then contained

in some way. Because the child was assaulted in the group, the experience of involving Social Care became the responsibility of the entire staff group, a shared experience, quite different from the responsibility for risk that a clinician working separately in a clinic can feel.

The staff member references four members of the team as being involved with the family. It may have been that the 'bringing together' of the family was supported by the staff group working together as a network around the family, whilst holding a united view on the need for the parent to be able to adapt his relationship with his child. This might be considered an example of what Rose (2011, p.153-4), refers to as "collective preferences", enacted when the group prefers and intends to achieve the best outcome "for the group and the individual acts as part of the group to achieve this outcome" (Ibid., p153). This suggests that when risk can be thought about and shared by the staff group, there need not be a process of projection into the individual that results in the burden of responsibility being carried by one person. This is an example of the playgroup providing a containing function, allowing for disturbances to be processed, digested and responded to, as opposed to this function being lost and pushed away as a Social Care referral.

Conflicts within the work

A task system is defined by Miller and Rice (1967, p.259) as comprising the "system of activities…required to complete the process of transforming an intake into an output…plus the human and physical resources required to perform the activities". At any time there may be different ideas of defining and implementing the primary tasks within an organisation and this can lead to conflict and disagreement. There may also be temporary shifts in the primary task that can lead to a redefinition of the way in which the tasks of the institution are understood.

The following example of work provided by a member of the professional staff

group, who was asked to identify a piece of work that she felt had not been successful. The example illustrates the conflict which may arrive within primary tasks.

> There's a family that I met with this morning where I feel my work has not been very successful. Initially the concern was about hitting and um pulling hair and biting, she's three. When I first met with Mum we talked about hitting and when I went back to her she said every time my son communicates with my daughter she hits, and I said is that a way of initiating interaction and how would you like to do it in a different way, and she thought about that and when I next saw her she said 'she's completely stopped hitting him, and I was like 'wow, that's a brilliant result', but then when I came back she said, and I was about to close the case, she said that things had actually started to go wrong again…if I'd done the ending at one point, quite early on, it (outcome measures) would have sounded great… but then I continued to work with her and things got much worse, it's made me feel quite, you know, they are a complex family, she's been re-housed because of really significant domestic violence…but I feel it makes me feel very, it's made me question other aspects of my work where I've actually thought things were tidy and actually it's maybe just that, the way I've sampled the time window, I've kind of come in, done some work and then I've ended…I think because she feels hopeless and disempowered, and I kind of think 'well, I've been in this job for quite a long time, it's not that there's a quick fix for these things, but actually I do know what I'm doing, but why, what is it about that contact with the parent that's making me feel I'm not doing a good enough job.' (professional staff member 4)

This member of the team talks about the range of feelings stirred up in her by her contact with this family. This includes feelings of self-doubt, hopelessness and disappointment. There is also an implied wish that she could have ended her work with the family sooner, so as not to confront the reality that her family strategies had not worked. She is trying to unpack what belongs to the family, what belongs with her training and way of working. She uses the tools of outcome measures, and what belongs to her, as an individual. The interplay of all of these factors demonstrates how complex the work is, in terms of the feelings that it evokes and the questions it asks.

There is evidence within the example of an internal work discussion model or framework in which these questions can be asked, without coming up with

definitive answers, (Rustin, 2008) as well as attempts not to see the parent critically but to reflect instead upon how the work has challenged the staff member.

This staff member highlights the way in which, according to Miller and Rice (1967), there may be conflict between the ways in which different systems within an organisation define the primary task. For example, she describes the normative primary task, (Lawrence, 1985) relating to the importance of positive outcome measures, a 'pre and post rating scale'. This is in contrast to the work that is required to be done, which in this case demands a deeper and longer intervention, owing to the complexity of the family. A poorer outcome measure result would be produced after more sessions, further risking the commissioning process. This is a reflection of the complexity and degree of need and is not an indication of a failed intervention, but of a deeper one.

The conflict lies in whether the priority is to produce the outcome measures that would enable the service to be re-commissioned, which in this example would have meant a more shallow and short term intervention, or whether there is evidence of a phenomenal primary task, which might be defined as being engaged in therapeutic work that is complex and cannot be accurately captured in the outcome measures.

It is apparent that outcome measures might be used as a form of defence against the potentially overwhelming feelings that a more intensive, longer-term contact with disturbance and pathology entails. Without attention and thought being given to the range of feelings that working closely with families provokes, workers will be tempted to close cases prematurely and to maintain a degree of distance from the work or to pursue an instrumental aim of ensuring that the service is re-commissioned through outcome measures that may not reflect the complex reality of the work.

While there were competing primary tasks beneath the surface, for the most part the Therapeutic Playgroup remained on task, according to its own

definitions, even though this was difficult at times. Professional staff member 4 continues with the work and manages to bear the feelings of sadness and disappointment that are stirred.

<u>Family difficulties and difficult families.</u>

While the work of the Centre was undoubtedly undermined by the increasing resource constraints and the reduction in high-level commitments, there were also ambivalences within the milieu of the project itself. Although the Centre's mission was one of outreach and inclusion, it was also recognized that it would not be possible to reach out to everyone in the community, and that some members of the community would feel indifferent about the opportunities offered by the Centre. In this part of the analysis if the findings I am identifying the ways in which this system could not always succeed in its own terms, and how staff responded to this.

Much of my evidence comes from what staff members told me in their interviews, and that what people say when interviewed and what they do may be different. However, I also observed what was happening, and did not have to rely wholly on the interviews, in which one might expect that some negatives would be underplayed.

A distinction is made by family support worker 4 between parents who do and parents who don't make use of the playgroup:

> Family Support Worker 4: I think it's not only communication when it doesn't work
>
> Interviewer: hmm
>
> FSW: I think it's need, like, our staffs um, how can I explain it? It's also down to them as well, parents. They need to involve as well, they need to like um, er, um, I can't find the right word, like support us, or work with us.

I: so, do you think a two way process?

FSW: yeah

I: so in a way they've got to be wanting to…

FSW: yeah

I: receive the support?

FSW: yeah

I: Do you sometimes think parents aren't quite ready for that?

FSW: yeah

I: or sometimes aren't willing?

FSW: sometimes they won't let us do our work, so I have to try, sometimes they think 'oh no', maybe something they're telling us aren't that important, maybe, so they need to be keen as well.

I: Do you mean that sometimes there isn't the feeling that parents trust what you are saying to them is a good idea to try?

FSW: It's not trusting, maybe it's that they are, I dunno, some parents are like, they don't bother.

Unsurprisingly, not everyone is felt to be equally responsive to what is offered. There are those who do want to become part of the playgroup work, and those who don't. This staff member makes a distinction between families who will listen and are receptive to the help or support offered by staff and those who are not, regardless of how hard the staff try. This is articulated by professional staff member 3 who comments:

When the parents don't want or can't accept it, it doesn't matter how skilled you are, or how good the team is, and there have been a few of those situations, although oddly some of those have come back so, erm, presumably they've changed their minds… (Professional staff member 3)

This suggests that workers are aware of the parents who appreciate and can make use of the work that is on offer and other parents who, either drop out of

the group, or make no attempt to shift their understanding of the difficulties confronting their family. This type of attitude or thinking about a client base is highlighted within the study carried out by Salmon and Rapport (2005), "conversations between professionals about interventions frequently refer to the perceived lack of willingness shown by a family to take up offers of help from an agency" (p.435).

The distinction appears to be measured by workers in different ways, depending upon the priorities of the individual staff member. For some, poor attendance to the group is a factor. The majority of workers considered parental anxiety about the presenting of problems as a measure of commitment. The difficulty in effecting changes is highlighted:

> I suppose we are dealing with families who are a long way from actually being able to really face up to what it would take to change. Or, to take on board what it would mean to change. (Family support worker 2)

There is a consensus that this inability to understand or communicate is located with the parent/s, and not the child, suggesting that the child's use of the playgroup is dependent upon the parent. Warin's study (2007) asks the question: "Is the service conceptualized as serving the needs of the child, parents, mothers, fathers, the child-within-the-family, the extended family?" (p.91) Warin asks whether a service is clear about who is the primary client. Schön (1983) also asks this question. This is relevant to the playgroup as there is a tendency among the staff group to discuss working with the parents more than working with the children. One might argue that the parents need to be engaged and worked with to be able to have any impact on the child, and yet I felt that in the interviews there was limited reference to the child.

The professionals' focus on parents rather than children might be understood in a number of different ways. Menzies Lyth's (1959) work, examining how the "primitive and overwhelming power of these emotions, tracing the anxieties back to early infancy" (p.74) are stirred up in the work of nurses might be thought

about in this context. The helplessness of young children, their vulnerabilities and dependence on their parents might make being in close proximity to the emotional life of the child anxiety provoking. Bain, (1998) also highlights the way in which being in intimate contact with children can lead to the members of an organisation creating defences that allow for distance and avoidance. One way of managing the feelings that are stirred up by working with young children is to restrict contact, and to in effect protect against one's own infantile feelings. This produces the exclusive focus on the world of the parent, which feels more recognisable and more tolerable.

The following interview extract is an example of a particular difficulty in working with a parent:

> Dad was very resistant facing up to the fact that he had a child who had additional needs so he was trying to, he was, I suppose what he was trying to do, to treat the child as if…I don't know, he was having difficulties accepting he had a child that he had to learn to understand. (family support worker 5)

Here there is a suggestion that part of the difficulty in working with this parent was his resistance and reluctance to acknowledge the needs that his son had; these needs were evident to the member of staff. The child is arguably the primary client of the playgroup, but the child/father relationship is central to the matter. The aim of an intervention is for there to be a healthier, more realistic relationship between father and son and that the child's behaviour might be modified through receiving a more attuned response from his father. The way in which the group becomes the setting for difficulties in families to emerge in a way that they can be thought about relates to Zaphiriou- Woods (2010) tracing of the purpose of the Therapeutic Playgroup, in which inclusion and containment allow for families to explore a range of difficulties with a varied staff group.

Perhaps this illustrates one way in which the primary task of the organisation, as Miller and Rice (1967), described, can shift from one moment to the next.

The first stage or task might be defined as helping the parent to recognize the additional needs his child has. This might be described as shifting his understanding of his child's behaviour. The second task would be to gradually find ways in which the child might be helped to feel his behaviour can be linked to his states of mind, and therefore provide a better understanding and response to behaviour. Thinking about the child's experience of himself in relation to the parent would be an important aspect in my approach to the work, whereas the focus for other staff members tended to be the parent's perceptions of the child. Despite differences in ways of approaching the work, the vignette demonstrates how the Therapeutic Playgroup remains working towards the overall primary task or essential goals of the institution, providing integrated and containing services for vulnerable families.

Other parents, who are described as not being able to receive help within the playgroup context, are considered to be manipulative, compliant, or unwilling to move beyond a passive position. This suggests a possible departure from the primary task or goal the Therapeutic Playgroup sets for itself. When the aim of giving these parents help can't be brought off successfully, this leads to a type of 'giving up' or to 'othering' these particular parents, to a resort to more exclusionary or coercive methods. Failures in this work are inevitable and so the question is how do these families get dealt within the central model of work?

> They came with probably a lot of preconceived ideas and were very good at side-stepping support, or using support in the way that they were making decisions, so not really using support for what it could give them, but getting what they wanted from the support, you know, so not open to change […] I mean they progressed in their own way but I think it was very, very frustrating. (professional staff member 4)

The staff member is aware that the complexities of parenting can stir up powerful feelings of exposure, and criticism is highlighted:

> I think because parenting is such a subject even where people are very confident in some ways can feel defensive and 'am I doing the right thing am I good enough?' (professional staff member 2)

The idea of there being a 'right' way to parent might be linked to the unrealistic 'magical' ideas that families have of what they imagine professionals can deliver. Yet there is also a belief held by the more responsive parents that there might be a staff perception of an intervention with a child rendering the parent and their parenting skills as criticized or inadequate. One staff member describes how important it was to overcome parents' anxieties about being thought of as "rubbish":

> Gradually, over quite a long period of time, I could demonstrate that I wasn't going to be saying "your child's got terrible problems and you know, you're a load of rubbish and your child's a load of rubbish", but to actually sort of build a positive relationship. (professional staff member 1)

While the staff member may actually have criticisms of the quality of parenting, part of the work is to be able to persuade the parent that something judgmental and disapproving is <u>not</u> taking place, despite the professional conveying that there is a need for change to take place between parent and child. The quality of how this is communicated appears to be an important aspect of successful engagement. There was some evidence of a team approach, and it seemed that if more than one staff member was involved, families felt better supported. This may be because various staff members were able to provide alternative types of support. For example, one family is described as needing a lot of support, but as "disappearing from time to time." There is no indication of why this might have been the case. What is seen as having helped the work to continue and the family to return was the telephone contact maintained with a family support staff member who encouraged them to return and to continue with speech and language therapy. This demonstrates the way in which the Therapeutic Playgroup could remain on-task in spite of the complexity of the family.

The suggestion is that if the professional staff member had had the responsibility for telephoning the family, it might have complicated the therapy, or made the relationship between parent and therapist over-intense. It is also possible that the parent might have felt criticized for having 'disappeared', thus

making it harder for her to return. The broadening of team support may have helped to dilute the powerful feelings that staff thought parents were experiencing, "you know you're a load of rubbish." It seems that a significant aspect of the work of the playgroup was to try to avoid parent-blaming, and to see the issue in terms of improving relationships and seeing different points of view.

The role and function of family support workers

The family support team was key to the outreach aims of the institution. The institution was reliant upon the family support team winning the confidence of families in order to make it possible to achieve more specialist interventions. For this work to be carried out effectively, the family support team needed the support of the professional staff group. There was evidence to suggest that in the pioneering era of the playgroup there was a strong commitment to joint working and to engaging a 'hard to reach' but a needy local community. This meant that the knocking on doors and initial contacts were valued by the institution.

The family support group indicated task distinctions both in terms of their role during a home visit and their role during the playgroup. The purpose of a home visit was to make the initial contact with a referred family, to explain what support was available and to attempt to establish a good enough initial relationship with the family for further work to be carried out. "We make the initial contact and we are asking the families "do you want family support, they say no, then fine'. (If) they say 'I would like family support' then we open the file". (family support worker 1). The opening of the file was described as symbolising the official start of a relationship between the institution and the family. It was understood that if a family said 'I would not like family support', this would be accepted and the team would not persist.

The family support workers' role within the playgroup was described by some staff members as the mediating of a relationship between professional staff

group members, or 'specialist services' and families, while others stated their role was to provide language interpretation and facilitate play. Other tasks cited were setting up and tidying the playgroup room and facilitating snack time and circle time.

Sometimes professional staff members met with parents in a separate room from the Therapeutic Playgroup space, while the family support team were responsible for caring for the young children who had been separated from their parents. Being in close proximity to this type of experience might have been managed in different ways. It is not possible to know how it was experienced, but my impression was that the impact might not have been openly thought about. The family support group were exposed to the range of responses to be expected from children about to be separated from their parents. The gamut of reactions ran from tears and other forms of visible distress to indifference and other behaviour which might be defined as demonstrating disorganised attachments. Left with the children, the staff might have also felt abandoned and left to manage, and provide some form of parenting function. One can speculate on the emotional impact of this kind of experience and what it might provoke in terms of early experiences.

Two members of the family support team were unable to provide examples of work with children, which I found surprising and troubling and could be understood in relation to Bain's analysis of day care social defences (1986). Perhaps these staff members found the close proximity to so many young children overwhelming and one 'solution' was to withdraw into a form of "psychic retreat" (Steiner, 1993) away from these feelings. However, one might also argue that the timing of the interviews, not long after a series of redundancies and staff having to re-apply for their jobs, might have meant that staff were anxious and unable to think about the work in the way they might have done in ordinary circumstances.

Generally, the family support workers were less confident in giving an account of themselves and seemed at times to struggle to find language that would

explain their attitude to the work. The interviews prompted me to think about the way in which child psychotherapists are unusual in having both a flexible professional identity and a theoretical language for putting emotional experience into words. The power of this language is evident in the way words such as 'containment', and 'projection' became part of the vocabulary used by the entire staff group.

In Menzies Lyth's (1957) study, the work of nursing was seen as arousing strong and mixed feelings in the nurse, including pity, anxiety and the hatred and resentment of the patients. It is likely that some powerful feelings were stirred up within the staff group, which were linked to feelings about being parented and being a parent.

One professional staff group member describes a piece of work discussion, for family support workers, which she had prepared with another professional member of the team.

> People felt a bit exposed, about how much they knew and whether they were doing things right, so we were very much trying to set up something that would enable a very open discussion about stuckness and boundaries and that sort of thing, but it was quite difficult, but an interesting process. (professional staff member 2)

According to this staff member, feelings around exposure and the anxiety of being seen as not knowing 'enough' were evident within this discussion group. This might be understood as existing within the framework of work discussion, in which "unexpected ideas and conflicts" (Rustin, 2008, p.12), emerge as part of the process. The difficulty some staff had in being 'open' in this group might have existed for a range of reasons. One interpretation is that these are feelings that are described by staff as being present in some parents who are felt to be guarded and suspicious of professional intervention. They fear criticism or being made to feel 'rubbish'. It is possible that staff were vulnerable to feeling some of these criticisms as a projection from parents.

It also highlights a potentially complex issue surrounding hierarchies of staff. While it may seem relatively straightforward for two professionals to facilitate a work discussion group for non-professional staff, it would appear that a range of feelings are expressed as a consequence of this piece of work. Perhaps this is an example of the organisation being 'open' about the internal hierarchies that exist and acknowledging distinctions between being professional and non-professional staff. Perhaps these distinctions are disguised in the relatively democratic ways of working together at other times.

This may be an example of the organisation making a transition from a lateral to a hierarchical or top-down structure of authority and in doing so the 'locus of leadership became experienced as ambiguous' (Armstrong, p.197, 2007) in the sense that this was a staff group established on egalitarian grounds, but there had been a shift towards a more vertical paradigm of authority for this particular piece of work.

Perhaps this piece of work discussion revealed aspects of the organisational reality that might ordinarily have been disguised, namely the fear of exposure, and feelings about the hierarchical structure of professional staff members and family support staff. I wonder now if one of the key functions of the child psychotherapist was to attempt to mediate this distinction.

The professional staff group referenced a spectrum of relationships with family support workers, from 'good' relationships with specific family support workers to some confusion about the role, "…there were stronger links with some, um, with some of them (family support workers) than others…" (professional staff member 2)

> A real challenge to me and still probably is, is the changing role of the family support worker and understanding their training and their um the way that they work, I suppose, is a challenge at times. (professional staff member 1)
>
> I mean, I think there are really skilled family support workers, it's definitely been helpful to be able to give, refer back and forth, so I think

they, you know, when I've got a good relationship with the family support worker you know it's really good to talk with them and they tell me if someone's circumstances have changed, for example if someone's not attending, they might phone them up and tell me 'oh, they are moving house' or they've changed their mobile, or something like that, so that's really helpful. (professional staff member 3)

The experience of family support workers is considered to be an important quality in terms of good working relationships. In contrast to this, the family support team did not reference the experience of professional staff members. Turner's (1962) hypothesis, that a role becomes a 'working compromise between the formalized role prescriptions and the more flexible operation of the role-taking process' (p.23) is relevant in this context, in terms of the perceived changing role noted by professional staff member 1. The role of family support worker suggests some degree of flexibility and adaptability because of the range of people to engage and the tasks required to be taken on, and yet it also appears to create confusion and uncertainty as to what the specific or more formalized role is meant to be.

The family support team spoke in admiring terms about the qualities of the professional staff and there was no questioning of their abilities. This reinforces the belief that a professional training makes it more difficult, or less acceptable, to query the expertise or experience of an individual. It links to the way in which Schön (1983) warns against the 'mystification' of professional trainings. He writes that "professions are vehicles for the pre-emption of socially legitimate knowledge in the interest of social control", (p.288) meaning that it less likely that professional knowledge can be openly challenged by non-professionals. It suggests that the "open discussion", which was described as being the aim of the work discussion group, would have been difficult to facilitate, because of the complex relationships between the two groups of staff.

It is worth exploring why 'experience' is raised by so many of the professionals with reference to the abilities of family support workers, and what they mean by 'experience'. Successful pieces of work with families are explicitly linked to specific family support workers by professional staff members. My predecessor

raised the experience of a particular family support worker whom she felt was particularly sensitive to picking up on issues surrounding domestic violence in families. My predecessor felt that if this could be taken up and thought about by the family support worker and the parent, it would become more likely that there work would be the possibility of a therapeutic alliance. Similarly, if this family support worker were not able to engage with a family when it was considered that domestic violence was likely to be an issue, my predecessor believed that it would indicate that working with the family in the context of the playgroup would not be possible. This reveals the level of work interdependency that existed between these two particular staff members. It also reveals the scope for developing a role based on the individual interests and strengths of the specific staff member. If one family support worker was perceived as the 'expert' in detecting domestic violence, this would inevitably affect the roles other family support workers held and the experience they were perceived as having to offer.

The entire staff group highlighted the importance of awareness of cultural and religious heritage. The proximity of family support workers to some families in terms of heritage, language and religion meant that professionals were often dependent on these workers to translate, or to provide explanations and a narrative regarding customs or traditions. The workers also provided a benign link between families and professionals in cases where communicating openly with an individual outside of one's community was a new experience. For some professional staff, this level of dependency on a colleague outside of one's discipline might have been a relatively unusual aspect of their work. They would have dealt with this in different ways. My predecessor described the need to refer to a Bangladeshi member of her CAMHS team from time to time, in order to understand the role of the man in some Bangladeshi families.

For some staff members the experience of 'not knowing,' needing to learn and often finding themselves dependent upon other staff members could perhaps leave them feeling that their own experience was limited. The term 'experience' may therefore be understood as a way of talking about the ability to engage with

families. These skills might need time to develop, but there were some staff who were equipped with these specific skills. One might also understand 'experience' as a way of articulating the degree to which it was possible for a professional and a family support worker to bear within their working relationship, the dependency and the need for communication that allowed both staff members to feel that there was the 'back and forth' as described by one professional staff member. This would vary between family support worker and professional staff member for a variety of reasons. The relationship might be framed within a 'container contained' model, (Bion 1962), with the family support worker providing a type of containment for the professional staff member in their contact with families, as well as containment for the family in their contact with the professional.

Some of the professional worker's criticism is expressed with caution in the context of uncertainty about whether the aims and hopes of the work were successfully communicated by the professional staff member to the family support worker:

> You'd want some people in the staff team to be modeling how to follow the child's lead in play with whatever and they never managed to do it, maybe that's a little bit extreme and slightly unfair but I found it quite difficult to get across the idea 'you're here, yes you're here to befriend the parents but you're also here to show them, to help them to be involved in the play of their child and to show them how to do that', but maybe that's unrealistic, because in a sense the befriending is how you get people to come, and to keep coming back so maybe that's all that is achievable by those staff members. Maybe I'm too ambitious and want them to be able to do too broader range of things, it's quite possible. (professional staff member 1).

There may be some evidence here of the concept of good parents and unresponsive parents, who respectively can and can't make use of the playgroup. There are the 'good' family support workers and "those staff members", for whom the really successful work appears to be beyond their capacities.

It is interesting to note how one of the normative primary tasks of the playgroup

is to reduce parental feelings of persecution and so make parents feel sufficiently accepted to become more tolerant of their children's behaviour. The parents can then begin to reflect with the staff group upon why their children might get into the states of mind that they do. This idea is described by family support worker 5 as "we can suggest that well, we know you can't do it at home, but here, just let him go, it'll be fine, it'll be ok." This worker's perception of the playgroup appears to be in conflict with the way in which more critical and disappointed feelings can be located in the family support workers. One might argue that part of the family support worker role that had developed over time was to contain some of the more critical thoughts and feelings within the team. This might also be seen as serving a protective function for families, preventing critical thoughts and feelings from reaching them.

There was a tendency for the family support workers to refer to the professionals' job titles interchangeably, such as referring to the child psychotherapist as a psychologist. The Children's Centre manager referred to the child psychotherapist as a CAMHS clinician, suggesting a move away from professional specificity. This shift from the personal staff member to a broader frame of reference might be understood in a number of different ways. It might demonstrate a lack of awareness of the differences between a psychologist and a psychotherapist. It might be expressing the difficulty talking about individuals as opposed to services, during a process of redundancy and redeployment. I also think that it might reflect a feeling that there was no significant difference between professional capabilities and that the important factor was the individual and how s/he worked.

Nightingale and Scott (1994) cite the specific pressure on staff as a result of organisational change, in which team members experience a pressure to be seen as "the same, in terms of competence, skills, seniority and training"(p.269). There may have been an element of this in terms of how people were perceived and described during this period of staff upheaval within the organisational change.

Overall, a number of individual family support workers had strong working relationships with professional staff members and this is where the majority of joined-up working took place. Family support workers were expected to have more than just an ordinary level of commitment to the work to be seen as experienced; to go 'above and beyond,' to engage families and to be particularly invested in the outreach aims of the work. Vagier-Roberts (2001) use of the term 'the self-assigned impossible task' has relevance in terms of what might have been expected from the family support team during institutional times of crisis.

The family support team is referred to in the policy statement of the institution: "a large percentage of the staff team is recruited locally, meaning that they understand the issues that the community face and act as positive role models" (source not attributed for anonymity purposes). This supports the idea that the family support role goes beyond the remit of an ordinary job description. There is the idea of a positive role model, being someone who not only belongs to and therefore understands the ethnic diversity of the local community, but also someone who is seen to have successfully challenged a cultural or ethnic stereotype and chooses to work in a multi-cultural environment. The family support worker can therefore relate to the local population. I am struck by how much is expected of family support workers.

There was evidence that this level of work expectation was achieved by some of the family support workers, who were clearly committed to their work. I think that what is less clear is whether professional staff members were also expected to fulfill some of the same expectations.

Where individual family support workers showed only an ordinary level of commitment, or some openly expressed ambivalence to the work (which was both relatively poorly paid and under risk of deployment or redundancy) they could risk being seen as not fulfilling the expectations placed upon them. Some staff members were under particular pressure to excel in order to demonstrate their "positive role model" credentials.

The broader issue is regarding the function of the family support workers, who are locally recruited, less formally qualified and closer in their ways of thinking to the families, in relation to the goals of the whole project. It seems that the whole system depended on the way this division of labour was managed. Each part of the work, carried out by both professionals and family support workers, is allotted somewhat different tasks or forms of work, but the success of the Therapeutic Playgroup depends on both of them being performed in cooperation with each other. They are sometimes in tension with each other, and each has its problems. The Child Psychotherapist has a role in making this relationship between the two staff groups work, in mediating each to the other.

Where this works, it seems to be an example of ways in which the overarching goals of the Therapeutic Playgroup (and the larger Healthy Living Centre of which it is a part) are met.

Referrals process

The conditions in which professionals can work with one another in relatively non-hierarchical or lateral ways are difficult to sustain and confusions and disagreements can arise.

When asked about the way in which the work was distributed and how decisions were made about the allocating of referrals, some of the interviewees stated that they needed to argue the case for referrals to be allocated to them.

In a number of team meetings that I chaired, new referrals were discussed and members of the professional team would explain why they considered themselves best placed to take on the new referral. Often there was a correlation between wanting to take a new referral and there being other members of staff already involved. This emphasises the importance of joint working and shared responsibility. It is striking that there were professionals arguing *for* referrals, which suggests that levels of commitment to doing the

work and being involved in cases was high.

Professional staff member 1 articulates a distinction between her/himself as an individual and him/herself as a professional working within a staff group: "[It is important to] think about the balance between your role as a professional and your role as a person, within a group of other professionals." This suggests a difference in terms of the decisions reached as a professional working within a professionally trained team and the choices made based upon personal work experiences. Perhaps this suggests personal preferences in terms of working with specific presentations.

Professional staff member 1 offers further information in terms of how difficult it was to become established within the playgroup, partly because other members of staff perceived the professional staff as being able to work with particular families presenting in particular ways.

> Children who at the age of three had very few, very little verbal communication would go that route, and I'd have to say, 'hang on a minute', but that's perhaps just my professional perspective on it, that I would think that you spot, a child who's got minimal verbal communication and you, my thought would be you'd think speech and language therapy straight away, but that wasn't actually the case, so perhaps a good lesson. (professional staff member 1)

His/her experience suggests that the established referral routes needed to be challenged. This required assertiveness and the ability to put forward a case as to why one intervention might be more appropriate than another. It also relates to different ways of understanding the problem, but in a different context to the parent versus the professional. In this situation the staff team had different ideas about which person or family referral goes to whom. This suggests some intergroup conflict and the possibility of disagreement, which Vagier Roberts (1994), warns can be avoided in some organisations.

The capacity to voice disagreement is illustrated in the above "hang on a minute", interview with professional staff member 1, and suggests evidence of divergent views being aired. It also suggests professional rivalry and difficulties

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in working relationships. Professional staff member 1 also describes not "really getting to the bottom of what it was she did" in reference to another member of staff. This is indicative of the friction and distance which may occur between some team members. It is unclear as to whether strains in working relationships may ultimately have led to members of the team deciding to leave. This information was not disclosed in the interviews that I conducted. These inevitable disagreements and differences were largely contained within the staff group. The method of work of the Therapeutic Playgroup places a premium on staff being able to appreciate and understand each others' contributions, the whole was made up of the various parts working together.

One professional staff member describes how she feels that certain referrals are made to her because of a remit within her role to carry out home visits:

> I've noticed when people are discussing whether a family should come to me, 'oh well you do home visits' and they find it hard to come in to the playgroup, can be a factor and will say 'oh well, why don't you work with them', because I think it's the nature of things. (Professional staff member 3)

Rose (2011, p.161), writes that professionals working in a multi agency setting might "have to adjust to a conceptualisation of themselves as non-specialists; or accept that achieving the goals of the team may not always entail use of their specialist knowledge. She also suggests loss is an unavoidable experience in this work. The above staff member is pragmatic in her approach to work but also expresses a sense of frustration in terms of the referrals being made exclusively to her because her role permits home visits. This is a particularly difficult area when one is in training, because it suggests the possibility of shifts in a professional identity that has not yet been fully established.

Two professional staff members comment upon a lot of "blurring" in referrals allocated to professionals, and the need for space and availability of resources being as important as which referral goes to whom. The idea of how 'established' a member of the team was considered to be determined to what

extent he or she was trusted and respected. Professional staff member 3 states that my predecessor, as a long-standing member of the team, made a significant amount of decisions with regard to allocations of referrals. This might be understood as referring to my predecessors' 'established' position in the team, but may also be linked to how she was seen as a senior member of the team with particular skills, such as informal management capacities. This suggests that the pre-conditions for successful practice and innovation were not only motivation and inspiring leadership qualities but also the idea of being 'established'.

Two professional staff members make distinctions between their work as individual professionals within the playgroup and their professional training. This suggests that through experience and after a period of time following qualification, choices are made about how to apply the training they have received:

> …While behaviourist approaches can be quite effective in some sense, I think it's more about what, understanding why the child behaves as they do, or why they function in different circumstances in different ways. (professional staff member 1)

> I think the training tries to, to encompass quite a broad range of approaches, but I think in practice people end up in situations that support particular styles or models, and hopefully you find the way that suits you. (professional staff member 4)

Both professionals are describing how the work shapes their approach to it – with the possibility that the playgroup has influenced and changed their way of working. It suggests that knowing which family should be allocated to whom might be a complex decision, taking into account the individual clinician's way of working alongside their professional training, together with their particular skills within the group. Despite some competitiveness about referrals, what comes across from the interviews is a general consensus that if jointly shared work could take place, it would help to allocate the work in an effective way. Both of these professionals show that they understand what is distinctive about the

playgroup. Professional staff member 1 shows she understands that the playgroup is not behaviourist in its approach.

> Sometimes, just talking helps, so after a while they (parents) realise that it is not a quick thing, but if you carry on doing things, you will see improvement. (family support worker 3)

The suggestion that 'just talking helps' touches on the essence of the Therapeutic Playgroup approach. The range of presenting difficulties or 'need', identified by four members of the staff group were described in terms of possible maternal depression and concerns or queries about parental mental health alongside challenging behaviour displayed by the child. This included extremely active or confusing presentations, with some staff members querying an autism diagnosis in some children. One presentation that featured in four of the interviews was a disturbed-feeding relationship between mother and child:

> I think in every case, nearly every case, the child wasn't actually underweight, we've got some very slim families around here, so they were small but in proportion, but the families, the mothers were really anxious and er, although I did not think that physically there was a huge amount to be done, it was really important for them to see in the group setting they will often eat things that they won't touch at home. (professional staff member 3)

This description demonstrates the way in which a presentation that might have been brought by the parents to the staff group as a specific feeding problem, or weight problem, could be formulated differently and contained by the staff group as something both emotional and relational.

Feeding problems were also discussed, but in a different way by professional staff member 5

> …In (the borough), you know, the stats are that many children are overweight, but when you talk to parents, particularly parents from the Bangladeshi community they, everybody thinks their child isn't eating enough and I think that's about how you care for your child.

Although there is discrepancy in terms of discussing children simply in terms of underweight or obese, both of these staff members formulate a difficulty relating

to the parental and cultural attitude to food. This is understood in terms of food being both relational and emotional. It suggests that there was a way of seeing the group context as important in terms of providing not only alternative models of eating and feeding, or of parenting more generally, but also in terms of helping parents to move towards an alternative way of seeing the child's difficulty. It suggests a way forward through detoxifying or diluting the intensity of the relationship between parent and child by the presence of other families and members of staff.

Part 2:

The Role of the Child Psychotherapist within the Therapeutic Playgroup

My experience of arriving to start work in the institution took place three months after my predecessor had left. Initially, the plan was that whoever replaced my predecessor in her CAMHS post would also take on this outreach responsibility as part of their role. However, there were delays in terms of recruitment and some uncertainty regarding how long it would take for the job to be advertised. My service supervisor was concerned about the playgroup continuing without a child psychotherapist involved. She felt that the playgroup was a long established, well-functioning institution and that it would be relatively straightforward for me to play an integral role in its development.

My "organisation in the mind": first impressions

My expectation was, that as a child psychotherapist in training, I would apply a particular understanding to family relationships, meaning unconscious communication, intergenerational patterns of relationships and early development. These were all of importance in terms of formulating ideas about disturbances in family life and child development.

I felt that there may have been undue haste to engage me in the work immediately, without time to learn and to gradually get to know the staff and families. I was expected to take new referrals from week one, and to help staff to complete paperwork that they felt anxious about. I also chaired meetings that I had not previously attended. I think this attitude to a new staff member reflects some of the anxiety that was being projected within the organisation; one professional can be replaced with another, there isn't space to learn and there is a pressure to be 'up and running'. I was aware of how hard it was to say 'no' to anything I was being asked to do. I can understand this as wanting to impress and please new colleagues which is something that most new employees grapple with. However, it also felt as though a mass of anxiety that

was looking for somewhere to reside was heading towards me and I can recall a wish to leave the role before I had officially started. (Source: Reflective Journal).

The institution expected and indeed needed a pragmatic and flexible member of staff, who would be fully immersed in the work from the start. I was expected to demonstrate my commitment and competence. It was as though I was being asked, "what can you manage?" "What is your capacity?" and perhaps even "what would you say no to?" "What would make you leave? (Even though we know you will leave)."

When I first met with the staff group I wanted to clarify that I wasn't a senior staff member who could simply carry on my predecessor's work. I was conscious of the desire to be seen as being as capable as my predecessor and how this could lead to taking on unrealistic amounts of work and responsibility. I recall that the times I was available did not conform to the expectations of the staff group; for example, because of my other commitments I would be last to arrive at the playgroup. This felt like a major disappointment to the team who had appreciated their time with my predecessor prior to the start of the playgroup.

I was asked if I knew how to complete a particular electronic form, which was new to the Children's Centre. This form was supposed to be completed and then reviewed on a six monthly basis with families. There seemed to be considerable anxiety about the completion and the monitoring of forms. There were also concerns about whether I had been on the relevant training. There was also an anxiety about the way in which these forms would be externally monitored and checked on by senior management, who sought to ensure Children's Centres were monitoring many aspects of the families attending. The staff hoped that I would take on responsibility for the completion and monitoring of forms. This made me feel that what I might actually be able to offer, as a child psychotherapist in training, perhaps wasn't what was wanted. (Source: Reflective Journal).

Although I felt that I had made clear to colleagues my relatively junior status at this stage without undermining myself, I left my first team meeting feeling reluctant to return and actually begin the work, because I might be unable to offer what the team wanted. The responsibility of completing the forms was ambiguous in that it was important and valued by the team and it is also a kind of mediation to the hierarchy. Form filling is also an aspect of the work that might be considered to be boring and getting in the way of the 'real work' with families. I think that there was an attempt for me to initially mind the implied responsibility, but also potentially anxiety provoking, time filling work.

It is, unclear to what extent being referred to as either a psychologist or as a psychotherapist mattered in terms of engaging families. My predecessor spoke about how she was initially known as the "family counsellor", a decision taken to make her sound more approachable and less clinical. She considered her accessibility to clients to be of greater importance than being correctly referred to as a child psychotherapist. One staff member spoke of how she thought the title 'speech and language therapist' could be intimidating for families, since it left no ambiguity in regards to why a child might be referred. She felt that the job title might stir up feelings of shame, inadequacy and anxiety in parents.

I was usually introduced to families was as "someone who can help you with some of your worries about…" I was occasionally introduced as being linked to CAMHS but never introduced as a child psychotherapist. I struggled with this because my child psychotherapist identity was still at a relatively early stage of development and my job title was one way of feeling more professionally secure. I was therefore keen to be known and referred to as a child psychotherapist. The difference between my predecessor's feelings and my own feelings about our job title suggests the importance of a certain type of lived experience, both in terms of work and security in one's own professional identity. Arguably, if one feels experienced and comfortable with the expectations of the work, a job title has less relevance than it would otherwise have.

The weekly team meetings are referred to by family support worker 4 as being closely tied to the work of my predecessor.

> We'd go to her (child psychotherapist) and that changed, because it became a proper… we sent the referrals and had a meeting at the end and we actually knew what was going on.

After one interview, I became aware for the first time of my predecessor having facilitated the song time at the end of the playgroup. Had I known that this had been part of her role in the group I would have thought about whether this was something I could continue or share with other staff members. I was interested in thinking about why I had not been told about this aspect of her work in the playgroup when I took up the post. Perhaps the staff members who facilitated the song time in the interim period between my predecessor leaving and my arrival were able and willing to continue. There might have been assumptions made that I did not want to do it, or that I did not have the experience required to sing in front of a group. I also wondered whether it was seen as something that had belonged to my predecessor and was part of the way she was seen as having been valued and that, therefore, aspects of her role could not simply be handed on to her replacement. Although I joined in with this part of the playgroup, I never led the song time. This role feels evocative of holding the emotional centre of the group- singing can be understood as an expression of group harmony. Song time was led by the Head of Family Support. I began to see this role as important in terms of symbolism and ritual, even though perhaps marginal in organisational terms.

Song time made me aware of how expectations might not have at first been directly communicated to me. A number of ideas or assumptions may have been made. In reality, I would have been pleased to take on this role, as I understood it as anchoring the families at the end of the group.

I thought about whether this type of thinking and relating was present in other relationships within the staff group. Assumptions about what an individual is willing to do, or not do, might influence how they are related to, and

consequently how they become positioned in the group, perhaps even enacting the assumptions. For example, as time progressed I would not have felt as willing to take up the song time responsibility as I felt I might have done at the start of my time in the playgroup. I think this is possibly because I would have felt a lot more self-conscious taking up this role at a later stage when I was established and known to staff and families. There is a window of opportunity at the start of a new post when a role has not yet been established and certain duties or tasks feel manageable and worth trying.

It was often assumed by new parents that I was a member of the family support team or a nursery assistant, prompting me to question why this might be. Was it my appearance or my limited ability to convey authority and experience, or was it because I was joining in with snack time and rhyme time and not behaving how families assumed a CAMHS clinician might behave? I would then reflect on my defensive reaction to being seen as a different type of staff member. Did I feel that being mistaken for being a nursery assistant was the same as being seen as inferior? Why did it matter? What was the best way of responding? (Source: Reflective Journal). Turner's suggestion (1962, p.23) that a role 'cannot exist without one or more relevant other-roles toward which it is orientated' has relevance, as I think I was experiencing some difficulty in understanding my role in relation to others, perhaps because I had not yet fully grasped the significance of my predecessor and what she contributed to the development of the playgroup, both for the staff and for families. While it was difficult for me to be seen as a member of the family support group, and not to be seen within my professional identity as a child psychotherapist, another way of perceiving this is that I was seen as accessible and as working outside of a formal status.

These feelings were at times difficult to process, challenging one's own feelings about hierarchies and professional identity. I often felt that families were not taking what I said as seriously as they might if they had attended an appointment in my CAMHS clinic. At the start of my time in post, I could often feel exposed without the 'props' of an office. A room and a receptionist help the

family and the clinician to feel more aware of roles. I wrote in my journal about a concern that I had about the quality of my work, I queried whether I was able to provide something useful to families in a way that I had not questioned in my work in the clinic to the same degree. In my journal, I considered whether families attending the playgroup might experience me as either too 'friendly' and perhaps too informal, or too 'distant' and in some way unapproachable. It felt difficult to get the right 'temperature and distance' which Meltzer (1976, p.374) describes, and is echoed by Daws' (1985, p78) description of how hard it is to position oneself in a way that feels right.

I was often aware of my body; how did I appear while sat on a child's chair, was it off putting if I had my arms folded while standing up? (Source: Reflective Journal) These were not issues I had worried about to the same degree in the clinic, or if I had they had soon faded. This may have been because issues surrounding the countertransference and transference situation are less chaotic in a clinical setting than in the community, where one can struggle with distinguishing between the different feelings and experiences; what belongs to whom. It is also possible that I was experiencing a countertransference relating to the unease and struggle some families feel about their attendance at the playgroup, perhaps they too are feeling judged, scrutinized and unable 'to get it right'.

Perhaps one of the most painful aspects of outreach work is the way in which one's own personality matters so much. Character traits such as friendliness, being persistent, or vocal, or relaxed, all seem to matter in a way that they do not in a clinical setting. It often struck me that one's own personality could greatly influence how the work developed. If one was able to get on well with and be liked by staff members, the likelihood of joint working or receiving referrals might be greater than if one was seen as shy, or distant.

The ability to be friendly, available and flexible comes more naturally to some than to others and part of this work is recognizing of one's own personal

limitations as well as strengths. I could sometimes feel that I wasn't 'cut out' for this work. (Source: Reflective Journal). This might be understood in relation to the work itself and how the parents' feelings of not being good enough or the right sort of parent become powerfully projected in to others in an urgent way. This might also be understood in the context of the institution, which was looking for a replacement leader following the departure of valued team members. Even with these factors taken into account, there remains something important about the personality of the individual in outreach work that might also be influential in other types of clinical work, but which is disguised within the more formal structures of clinical work. This feeling might also be understood as a type of projection, of not feeling good enough or committed enough to work in a setting that has been established because of the interest and investment of a small group of people of which I had not been a member.

My own experience of choosing whether or not to assert myself occurred during a staff meeting held within a couple of months of starting the work. I was concerned about a child who had attended for the first time. He had refused to eat during snack time and his parent had persisted with trying to make him eat until he had collapsed into a combination of painful crying and angry lashing out of legs and arms directed at his parent. The parent had restrained her child while becoming increasingly upset and keen to leave the group, she had gathered together the child's coat and lunch box. I fed this back to the staff group and spoke about how I had felt that this child had become inconsolable and how difficult it had felt to know how to support the parent, or how to communicate with the child, partly because of how ashamed and alone the parent seemed to feel in this situation. There had been something quite paralysing about the experience and I had wondered whether the parent might also feel something similar in relation to the child. (Source: Observational Notes).

One staff member responded by saying she had felt this incident to be within a normal range of tantrum behaviour. She had spoken to the parent and had

found out that she lived just outside the catchment area of the playgroup. She had given her a map of a neighbouring Children's Centre and suggested that they attend a playgroup there. She had also given the parent a worksheet on messy play to take away with her.

My way of understanding and responding to this situation was informed by my child psychotherapy training. Work discussion and supervision enables thinking to develop about the emotional impact of the work, combined with complex issues about roles and authority. I felt there might have been a wish to move this 'messy' family on to a different centre and to different staff, because of how disturbing or paralysing the incident had been. Finding ways of opening this up to other staff members was important, as was not becoming 'territorial' about my way of seeing the family. However, I also felt that it was important to acknowledge different ways of observing what had happened. I could see how there were ways of restricting contact with families in a way that could constitute a form of defence. Other members of the team were crucial in terms of offering further thinking about this incident. This resulted in the family being invited to return the following week and to continue to make use of the service. (Source: Reflective Journal).

My experience and role within this work can be linked to the goals and methods of a Therapeutic Playgroup. I was able to experience the difficulties and the tensions from 'within' the work, but that nevertheless I was able to function as the playgroup needed me to, in terms of remaining sensitive to the needs of families and not resorting to premature action which would result in families disengaging or being excluded. My contact with the playgroup was more fraught and complicated than the picture that emerges from the interviews with staff, but it remains broadly consistent with the aims and tasks of the Therapeutic Playgroup model.

<u>My role and the role my predecessor held</u>

I did not have the opportunity when I began my placement to meet with my predecessor to talk with her about what she considered to be her priorities in the role, because she was then in a new post and time had passed since she had left the Children's Centre. With hindsight, meeting with her would have helped to gather in my own ideas about what the work involved and what I could do and what was beyond me at this stage in my career.

She describes how the playgroup was initially named a 'community health group,' because the title was considered less stigmatising than any other proposed title. The starting point for the work was not a playgroup but the provision of workshops for parents accompanied by their children. She states that there was a programme of workshops and that these workshops aimed to educate parents in the importance of understanding children and what children communicate.

> Parents who had been more used to, (pause) well, at that time they were more used to sort of feeling that you had to control something. In order to control a child you had to put them in a particular place or smack them, that was what was, sort of strategies were, so sort of thinking more about different kinds of strategies and how to understand children a bit, where there wasn't an understanding.

My predecessor would run some of these workshops alongside the Head of Family Support, who would act as an interpreter and facilitator. The workshops would run at the same time as the drop in stay and play group. The workshops and playgroup evolved over time, so that the "children were slightly more contained by the crèche workers". (predecessor child psychotherapist).

The work had started 7 years before I had begun and the background history enabled me to better understand the gradual development of a service. My predecessor had started her work in the institution as a teacher, providing parents with insight and advice about children's behaviour. She moved from this position to become established as a professional with something clear to offer the institution. I was also struck by how closely she had worked with and relied

upon the support of the staff group, both in terms of her workshops and also in terms of the staff looking after children while the parents spoke to her. This way of working would have meant that all of the staff group were involved in the workshop and working closely with the child psychotherapist and her approach to understanding childhood and emotional development. Becoming aware of this history made me aware of how the project had become deeply established in its culture. The valuing of 'experience' is foundational to child psychotherapists' outlook and training. Bion's work (1962), on 'learning from experience', and the idea of 'emotional experience', as well as the contrast between different kinds of 'knowing,' show how central this concept has become to psychoanalytic thinking.

'Experience' is not simply a raw unprocessed sensation to be reformulated in professional categories, but rather what one can learn from given particular reflective capacities. This leads to different assessments of who knows what within the team. It might be easier for a child psychotherapist to recognise the contribution of the family support workers than for some other professionals, who had a more 'closed' idea of expertise. It might also be the case that during the earlier days of more shared work and the setting up of the service it was possible to attach greater value to the work of family support workers. There is little evidence in the data that would suggest that the family support workers holding managerial positions were seen by the professional staff group as having more or a different quality of experience. One possibility is that as changes to the institution took hold, ideas of expertise narrowed and 'experience' changed in meaning.

When I look back I think that agreeing to chair the post playgroup team meeting was a mistake. I had not wanted to say no at first and risk letting down the team who seemed to expect me to take on this role. I was torn between feeling that I did not have the authority and feeling that perhaps by chairing the meeting, I would gain the experience that I lacked. I think that I needed more time to learn about the work by being in the playgroup and working with the family support team, before accepting the role of chair. When I think back to that time, I am

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unable to think of who else might have taken on the weekly role and perhaps this is why there was pressure to agree to it. I was one of the only staff members who attended each week for one year. I don't know what would have happened if I had said no. I came to feel that I had failed, from a counter transference perspective, but perhaps it was a solution to the situation at the time. Despite being exposed to some painful feelings, on balance I was able to hold the chair function for most of the time.

When the weekly meetings were later reduced to monthly meetings, I felt some sort of responsibility for the change, as though it had been decided to reduce the frequency of meetings because I had not managed to chair it effectively. While I understood that this was an institution in crisis and that the change had been introduced by a new member of staff, I still felt that I had been unable to contribute to the success of the service. The way in which I experienced this as being a personal failure suggests, with hindsight, that the position allocated to me by the staff group was one in which unwanted feelings such as rejection and failure could be located within me. Much of these experiences are evident from Cohen's work (2003) in the neo-natal unit, as she too felt that she was a receptacle for unwanted feelings from others.

Anxieties in an institution or work group will tend to result in a form of splitting, through the projection of anxiety and blame (Obholzer, Vagier Roberts, 1994). In this case it seems likely that the anxieties arising from loss of staff and uncertain staff commitment to the institution may have been the main cause for projecting anxiety. There may well have been a feeling that my predecessor was irreplaceable and therefore the institutional disappointment must be located within her successor.

The previous child psychotherapist in post states that the "infant within the parent, that is the experiences of the parent as a child, and how this might manifest in the here and now with the child" were conceptually important to how she worked. This fits in with the way in which Urwin (2003) wrote about the "emotional life of the child", and the phantasy which manifests itself in play that

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informed how she worked:

> It is attention to these processes that informs the therapist about what to ask, and when, about the parents' own childhood, to facilitate freeing a hitch in the parent – child relationship, for example. (p.383)

The similarity in the approach to the work suggests that the theoretical framework used by child psychotherapists provides clarity as to who is standing for whom in the professional relationship, which enables a formulation to emerge for understanding the family presentation.

The previous child psychotherapist describes the particular kind of work that she felt was most appropriately referred to her as a child psychotherapist:

> People were recognising that there were difficulties where there were a combination of things, say, behaviour, perhaps some physical disability, or learning disability, um, and something more enduring, perhaps in the parents in terms of them being for example, un-reconciled with a diagnosis that their child had been given, or very anxious about feeding, or whether there was an emotional component to the parents' response, really, and the Health Visitor felt was beyond normal health visiting strategies, then they'd sort of send them to me and if there was a speech issue me and the speech and language therapist would do these together.

My predecessor states that the institution:

> …Exemplified how you can actually do something reasonably quickly, to contribute to making a difference both to a family, context, you know the difficulties between the parents, the father was sort of long term unemployed, depressed, and mother felt let down by him, she'd wanted a husband who could provide for her and you know, um, and a father who had his own history or kind of abuse, really, and had not resolved that, and began to then see it, how, the influence of that history on his own parenting of his son. Um, and the son's behaviour, which had been head banging and very challenging behaviour, how that kind of diminished, well stopped, really. And, you know, just a number of different elements contributed to make something that made a difference, all together, then being able to put him in touch with the clinical psychologist working at the centre, who did an assessment of the Father, and he got help in his own right, which he never had taken up properly before, sort of in a very kind of, revolving door GP-patient, you know, nothing would ever work, it was no good, and so on.

This suggests how strongly she felt that the model worked, and how the formal objectives of outreach, inter-agency work can be successful. This is an idea which is in keeping with the institution's formal objectives described at the beginning of the analysis of findings. Feeling that the model of work is effective and successful is an important part of one's commitment to the institution. She describes how, by working with the whole family and by using her understanding of how parental relationships and states of mind affect the child's development and behaviour. She also highlights being able to refer to other professional members of the team for particular work to take place. Using these techniques she was able to provide a shift in the family's chronic revolving door experience. Her description fits with Zaphiriou Woods (2010, 2012) discussion about the origins and aims of the Therapeutic Playgroup, in terms of 'offering relationships and experiences which encourage mutually and progressive development'. (2010, p.231)

As a senior member of the team, my predecessor had taken a key role in the development of the service, including the role of informal supervision for the family support team. She spoke to me during the interview about how she had hoped one member of the family support team might go on to train as a child psychotherapist. This reflected the different stages she and I were in our careers. I think she was able to nurture and help others to build confidence in their work, to help others to use their emotional responses to inform their work. I was still being trained and I needed to be nurtured and supported. It seems clear to me that one is more likely to be successful in institutional settings if one is mindful of the needs and the development of others in the team.

As part of the interviews I asked each member of staff whether they thought the child psychotherapist held a particular role in the work. One member of staff with management responsibility said:

> I think what she (my predecessor) provided was a bit different and it must have actually been quite hard for you to follow on from somebody you kept hearing 'ohhh she was lovely!' (Laughs) But, she had an incredible knack of even in the busy set up, she could provide a little quiet oasis

somewhere in a corner, and I think was able to get the parents to have quite an in depth discussion about, not so much the immediate situation, but going back, you know, where it started and it gave them a chance to talk about really important things, the pregnancy, the birth and what had happened to the family dynamics, so I think that was a great benefit for a start, for her to be able to understand the situation that people were in and er, give them space to talk about things too, being stuck with a life that was, you know, quite often they were really hating.

She was always able to bring to the discussion afterwards that there was a child protection concern, so we'd talk about it, but even if we did have to take things further it did not seem to destroy the relationship… Oh, the other thing I got from her and you is supporting the group, you know that's really valuable, and as an individual makes you feel supported and she was certainly observant, she'd really pick up if someone was feeling fed up, for instance. (professional staff member 2)

For this member of staff, my predecessor seemed to embody the values of the institution, in terms of being able to make meaningful contact with families and staff in a busy and informal setting. There is also a suggestion that the relationships built with families can withstand and bear the possibility of there being some risk, without there being the need to resort to premature action. Then if children's statutory services do become involved, the relationship with the institution (and staff member) can be maintained.

How might a child psychotherapist work differently from other professionals within the team? The answer appears to be about complexity and recognising complexity for what it is, multi-layered and hard to engage with. My predecessor cites how she would formulate an understanding of a family's difficulty:

So, I might kind of come up with a formulation for me and they might have a very different idea, and in some ways, I suppose it was about me moving more, me moving closer to where they were, and them also maybe moving closer to where I might be. Trying to bridge that gap, and some of that I think was a psychological transition really, to thinking about things in a different way. One of which is: children understand things and there is meaning to how they communicate, and what they communicate through behaviour.

One might describe this as a form of what Schön (1983) describes as reflective practice, in terms of an awareness of one's own formulation and how this differs

from the family's ways of thinking, as well as a process of 'continuous learning'. A process in which the family's perspective is not dismissed or seen as wrong suggests a flexible working model, which allows for shifts and adaptations from both perspectives.

Gaining the ability to develop the capacity to provide emotional containment for families is an explicit part of a child psychotherapy training. The trainee learns from the close write-up of notes, the relationship with supervisors and the personal psychoanalysis which forms the foundation of the training. The language of containment has crossed over from psychoanalysis, into the terrain of different professions and disciplines. This links to Dilys Daws' (1985, p.80) stark warning not to view psychoanalysis as 'belonging' to any one individual, or discipline.

My predecessor is clear about the limitations of what is achievable in the institution:

> I think those, and you know there were quite a few instances where, you know, we really kind of thought 'actually this Mum is really depressed', um and you know, there is an impact on the child, very clingy, or feeding problems, and we could not do very much about it, and so that was quite difficult. And the father wouldn't come to the fathers' group, you know, so yeah, there comes a point where you can't, just can't do things, really.

Knowing this and being able to articulate this means that there is less likelihood of taking on work that requires inter-agency working, and, as a consequence finding oneself taking on unmanageable or inappropriate levels of risk and complexity. This is one of the difficulties in non-clinic situations such as the playgroup. Understanding the boundaries of what is possible and what is not takes time and work to understand.

There are several reasons to suggest why a child psychotherapist is valued by the team, possibly even above some other professional CAMHS disciplines. Some reasons are tied more specifically to my predecessor as an individual, since she had the personal skills and commitment that fitted other key staff

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members' values and beliefs. She knew when to ask for help and support, as she references members of the CAMHS team with whom she consulted.

The role of the child psychotherapist within a Therapeutic Playgroup is to pay attention and be sensitive to providing families with opportunities for experiencing careful attention and thought. The strains on parents, looking after children who may be projecting intense anxieties and hostility, are supported and contained within a group setting, supported by a number of staff invested in supporting emotional development. The high number of staff allows for each member of the group to receive time and attention. The role of the child psychotherapist within this is to be able to provide a quality of attention comparable to the clinical situation, in that it provides containment, but within a busy and noisy setting.

The ways in which my predecessor was able to work with staff and families that meant the team had come to experience the value of child psychotherapy. This is the picture that I have been able to gather of my predecessor, from interviews and my experience of following on from her. However, the interviews also suggest that there may have been different ways of seeing her work and her role in the centre. Two of the interviewees were unable to clarify what her specific contribution was to the team, which suggests that her relationship with some staff members was stronger than with others.

Part 3:

Change and reorganisation: the impact of contraction and uncertainty

The institution that I heard about in the interviews was different in many ways from the institution that I came to experience. My impression from the interviews and the contrast with the experience of working there was that the institution had passed something of a 'golden age' by the time that I became involved. This was in part owing to the departure of key members of the team, as well as the institution being threatened with closure and imminent re-organisation after just a few months of working there. Despite these changes, there were aspects of the work that has retained the values and aims of the 'golden age' described by many staff members. From the interviews, there was evidence of historical lateral relations (Armstrong, 2007) within the team. A small group of professional staff and one senior family support worker were felt to have held more authority than other team members, but the professional staff sought to nurture and value the experience and contribution of all team members in a way that sought to minimise any hierarchical structures.

Some distinction is made by staff between the historical purpose of the playgroup and the more recent client base:

> Initially, it was a way of addressing some of problems which were going straight to hospital [...] which could have been addressed...in house."
> (family support worker 4)

The recent client base is spoken about using terms such as "needy", "vulnerable" and "hard to reach", as well as being "suspicious" and "guarded" in their contact with professionals. The later shift in the targeted population seemed to be linked to the concern of key members of staff that ethnic diversity such as in the case of Bangladeshi families was not being addressed. The number of referrals to CAMHS and Speech and Language therapy services was cited as evidence.

There is a broad degree of consensus relating to the more recent service being for the use of complex families with a range of needs, as opposed to families who would have habitually attended hospital Accident and Emergency departments for help with their child:

> I believe a family will come to us if they are vulnerable, that's why they come to us, if they are [a] mainstream family they will not come, they will easily go to the health professionals, or they can easily access the services. (family support worker 1)

The implication is that the outreach nature of the Children's Centre setting is not necessary for families who can request referrals to specific services and attend appointments.

The previous child psychotherapist explains that, owing to the increasing number of families attending the playgroup, it became impossible to "hold all of the families in mind". The service adapted and became more targeted and focused in its objectives, as a result of it becoming 'too successful' and popular. The targeting of those in most need who attended the play group meant that staff were increasingly mindful of those who were expected to attend but who had not and therefore required some form of follow-up and liaison work. Institutional survival, as opposed to continuing to cultivate ways of working with vulnerable families, became the major preoccupation during my time there. This suggests a move into Vagier Roberts (1994) definition of 'the self-assigned impossible task', without the resources to support the employment of the staff running the playgroup, the shared ideology to engage a difficult to reach community had become contaminated with ideas about surveillance.

With my predecessor having left to take up a more senior role in a different service, and with the speech and language therapist having also left the group to resume previous management responsibilities, the remaining staff group was left in a state of flux, uncertain of the future. The speech and language therapist was not replaced during the time I worked in the institution and I was acting as a temporary replacement for my predecessor. The two health visitors, once a

weekly presence, began to attend sporadically and one health visitor was transferred to a different Centre. The remaining health visitor declined to take part in the research, stating that work commitments prevented her from doing so.

I began to think that my arrival signified the beginning of the end of something that had been valued and successful and I thought that others shared this view. I believed that some staff may have been disappointed by a senior and important member of the team being replaced by someone in training, who might have been as inferior and lacking in experience. I even began to wonder if a culture of disappointment and dejection was developing as a result of there being fewer resources available. There may have been general concern that staff might be left with more to do and with less support, or that any one person might be blamed for not identifying risk or mobilizing child protection procedures. I also thought about how I was not really able to understand what was happening in the organization because I was fairly new. I speculated as to why the first person, the original Health Visitor, had left. Did it reflect something about the institution no longer functioning as it once had, a wish to escape? Or was it circumstantial and not related to the work of the institution, since, after all, each of the professional staff group had other concurrent sources of employment, outside of the institution and it is to be expected that they will seek other opportunities as their careers progress.

In the interviews with professional staff members there is evidence of a greater allegiance to one's profession than to the playgroup team, with references to 'us,' being a reference to professions rather than teams. This is suggestive of a retreat from lateral relations to something different. Without the founding professional team members to hold together a team boundary or 'its own sense of sameness (for no one else has the experience out of which such a boundary can be both found and made), (Armstrong: 2007, p.201) a shift into 'hierarchical styles of functioning' occurs (Garland: 2010, p.248). The impact of the uncertainty and contraction resulted in an erosion of the central purposes and

methods of the Therapeutic Playgroup and the Healthy Living Centre. This was demonstrated by the retreats to hierarchy and specialisms.

It wasn't clear to me why key people had started to leave, considering that there seemed to be such considerable personal investment in the work and identification with the team and its objectives. Rationally, one might not expect a decision to retire or to take up a senior position elsewhere to be the outcome of what was happening in the institution, but I wondered if it was. It did appear that a number of key individuals had left in a short space of time, which felt something of a vacuum in terms of leadership and direction. I speculated that less commitment seemed to be producing more promotions and retirements.

It is important to reflect upon the time and context in which the interviews took place. One of the prevalent themes running through the interviews was the sense of an era having ended. I wondered if time and distance had served to gloss over the actual difficulties encountered in the previous phases of the institution's history.

> As a professional you see the speech therapist as a gift, it's such a bonus, and the parents are really happy to sit with a speech therapist here, who of course we've lost now." (family support worker 3).
>
> It felt like a bit of a luxury, to be honest. (professional staff member 1 describing her role in the work retrospectively).
>
> It was a landmark, exemplar place, you know, people wanted to come and see for themselves (family support worker 2)

The past is described with a degree of nostalgia and some idealization by four staff members. Yet what is also conveyed by one member of staff is not a straightforward sense of nostalgia, but some acknowledgement that the past set-up of the Centre was not universally admired and appreciated, despite an apparent richness of resources.

This may have reinforced the feeling of loss.

…there was one of the nutritionists who came in and er, we were also really lucky to have an artist for a while and she was doing some beautiful portraits of children […], we also had the homeopath, which was a real asset. I don't think she's there anymore […], And I think you either love or hate that […] People don't like the clinic now because they never see the same person and the artist has gone and I doubt that there's a corner for people to do palm prints, I think that has all gone, the homeopath's not there, as far as I know, so it's um, probably easier for the poor medical students to pop in if they want to, but I think it has changed. (family support worker 2)

While changes to funding and cuts accounted for the reduction in resources, there was also an indication of changes to the ethos and leadership of the institution. One staff member states "when the wind changed and there was more of an emphasis on education, I did not feel so comfortable attending, and so I did not, but that person has gone, and I haven't". This suggests how influential one individual can be in the context of this institution and how staff can withdraw from the institution in response to changes in leadership styles.

A long-term and highly valued member of the team stopped attending the playgroup a few months after I began. In the meetings following on from the playgroup I asked if anyone knew why she wasn't attending, but no one did. I felt concerned about why she had left and wanted her to return, and I therefore made contact with her. She explained that she felt "bossed around" by a particular member of staff, who had photographed her for a new wall display of staff, without seeking her permission to do so. I tried to encourage her to return, suggesting we find a way of speaking about the matter with the relevant member of staff to try to find a way forward. She was initially reluctant to return but did so about a month later, following another phone call from me. (Source: Reflective Journal).

This experience made me very aware of how staff could absent themselves from the work without managers and their colleagues reacting. The work of the staff outside of the playgroup group meant that it was possible for work schedules to be changed and withdrawals from the playgroup to occur. I felt a powerful sense of the fragility of the staff group and the work that was needed to

ensure that relationships between staff members were properly understood and supported; also how quickly the 'wind changed'. Having worked hard to re-engage with this staff member, I was struck by the possibility that my predecessor may have held a vital role in terms of staff relationships because there appeared to be no other staff member who would have fulfilled this role and how I had found myself stepping into this role. (Source: Reflective Journal)

The ways in which the loss of staff was discussed shared many similarities with the 'drop in, drop out' nature of the client base. Both staff and clients left the playgroup often without a clear narrative explaining why.

One member of staff describes a specific family, about whom there were many child protection concerns. The family had chosen to drop out of the playgroup on a number of occasions:

> There was the mobile phone number that was either off or was taking messages but there was no response, and erm, and at one point they did not seem to be at their address anymore so, so I think we did lose contact for quite a few months and there were letters being written as well, you know, just sort of inviting them back, all very low key, er not an order, just a suggestion that we were still here and they might like to come in and we'd like to see them. And none of this particularly worked, but then they did pop up again. (professional staff member 3)

This description reveals the staff's approach to maintaining contact with the families. The reappearance of the family is experienced as unexpected. One staff member described an internalised image of an open door, which she associates with the playgroup. This image appears to be both welcoming and optimistic, but also suggests that containment is always limited, because an open door can also symbolise a leaky container.

> It was very difficult. I think there's some kind of, sort of hypothetical, no it's a real door, but it's also a mental image of the door is open, and they can… of course, it's a drop in session. (professional staff member 2)

Three other members of staff spoke about the way some families 'disappeared' from the playgroup. The drop out nature of the playgroup seemed to represent

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for some members of the team something irreconcilable about the way it worked. The attempts made by the staff to re-establish contact with families, while trying to bear the 'not knowing' had created a feeling of helplessness for some staff members, which was one of the most challenging aspects of the work. This links to Urwin's (2003) comment that there is not an obvious agency to refer families on to, and how problematic this can be. There was the suggestion from the three members of the team that a feeling of failure had to be sometimes tolerated. The link was made between a family dropping out of the playgroup and a failure to help them. The surprise reappearance of families was often difficult to explain or to even understand. This might be seen as sharing a quality of sudden decisions made by the senior management in relation to staff changes and redeployment.

Family drop out can be thought about in the context of staff and organisational changes. The similarities were striking in the sense that it was difficult to find an explanation to describe why staff and families left. There was a similarity in the way that both types of departure were tolerated; not understanding why was part of the narrative. The implementation of the work discussion model (Rustin, 2008) would have provided valuable opportunities to think and share ideas about why families disengaged.

The professionals who had taken jobs elsewhere, or had retired and not been replaced, seem to have also been experienced as having 'dropped out' or 'disappeared' from the ideology of the playgroup. The future seemed unclear and although interviewees spoke of former team members with respect and almost idealized admiration, the group ethos had suffered. There appeared to be a degree of ambivalence in the face of loss, a sense of personal abandonment confronting idealization of former employees.

Six months into my involvement with the playgroup, the family support team were faced with the situation of being made to reapply for their jobs. This took place just under half way into my time in post and I felt it was a violation of the mission of the institution. During the first six months in post I saw a fairly well-

contained and stable situation, even though two key members of staff had already departed. In the second part of my time in post I found that staff were being threatened and the aims of the work were also threatened. I cannot be certain about what the staff were told in regards to the reapplication process. I was told by a member of the family support team that they were all concerned about losing their jobs. She feared losing her job if she were to take annual leave.

Some of the interviewees' attempted to remain uncritical in their replies. One family support worker repeatedly expressed how much she loved her job and how important it was to share information in the multi-disciplinary team. Her answers reminded me of a job interview. A second family support worker felt surprised that her interview had not taken as long as I had predicted. She asked me whether she had done something wrong at the end of the interview. Two family support workers spoke about how well the group worked and how effective the multi-agency model of the playgroup is, but were unable to provide a vignette or a single example of a piece of work that they felt had been successful.

One way of understanding these responses is a reaction to the many uncertainties in the organisation at the time of the interviews. It is interesting to note that there is little negative feedback about the cuts or redundancy from the family support workers. For example, family support worker 3 says:

> Obviously, Government doesn't have much funding, and er it's limited, whatever funding we have for the activities and everything, but it's not bad, it's ok.

This comment is in response to my question about what might be important to hear from the workers regarding the recent cuts and changes and the consequent pressures on the team. Family support worker 2 comments:

> I don't think it effects any sessions or activities because we are running our sessions and our activities as we did before, so I don't think it's effecting families or anything.

However in a later comment she noted, "Staff are being like, um, transferred to

other Centres". There was an attempt to remain optimistic and professional, but there was also a sense in which some of the responses are guarded and cautious.

It is interesting to note that the professional staff members were more vocal in their responses to questions about the impact of cuts to the service. There were comments about the destructive impact on teams that are re-commissioned at late notice. Three professional staff members spoke of their doubts about the ability to provide a service such as the playgroup in the future. They said that it is an "easy" service to cut and spoke of the difficulty in achieving the "cross agency co-operation" required to maintain the staffing levels of such a service. This suggests that the professionals were more aware of the funding and management side of the work, or perhaps that they were less guarded or fearful of the consequences of speaking about these issues.

Professional staff member 4 commented that she felt "we need more of an ego, to boast about our successes", in line with my thoughts about there being a current vacuum in leadership or leadership function. Rose (2011, p.160) cites the "force'" of the personality of the individual as a powerful factor in decision-making. This suggests a belief in the need for a particular type of personality to drive the service and to support the team.

One member of staff with management responsibilities had found herself having to reapply for her post weeks before being interviewed by me. She commented:

> We, as a result of the cuts are no longer part of the voluntary sector and we are now under the local authority. The changes we have seen are really quite slight in many ways. I mean we don't have a reduced team, we have a reduced admin, um, which is problematic, our biggest problem is reduced space […] so it's sort of changed how we can operate a little bit but I think doesn't make it impossible for us to work at all. (family support worker 5)

There are a number of different ways of understanding this. How she perceived me, as someone from outside of the Children's Centre, and a temporary member of the staff group, might have had an effect on her choice of language.

There may also be some guardedness associated with the research itself, such as who might read what she had said and how this might reflect on her and her organisation. I was struck by how she spoke not about the Therapeutic Playgroup, nor the Children's Centre but the wider institution. Perhaps one impact of the cuts is to think less about specific services and tasks but in a more global and general, but also an anonymous way.

Bain, (1998, p.12), cites the unconscious social defences within a nursery setting as including "the attitude that all nursery nurses are much the same and easily replaceable, and therefore it doesn't matter if the nurse leaves." (p.12) The loss of a longstanding   member of staff may not be acknowledged, but the loss of a member of the administrative staff is noticed. There is a sense that the impact of change is being minimized. This might be understood in terms of finding a way of managing the anxiety relating to change and unpredictability. It is also striking that the change can be spoken about in terms of reduced space, a concrete manifestation of something being taken away, but not in human terms.

There was evidence of some confusion about why staff members had left the playgroup. One Family Support Worker thought my predecessor had left because of a change in funding, or that she had been moved, in a way similar to the Head of Family Support. This was one of only three direct references made about specific members of staff leaving. One member of staff commented, with reference to what she felt the Children's Centre could provide in the future:

> Rather than be expected to run more groups which we can't, what else can we do, um, and also the professionals are being sort of drawn off, we don't have a speech and language therapist with us any longer, do we? (family support worker 5)

My own experience of the uncertainty of the future of the playgroup was reinforced when I arrived one day to find that the Children's Centre was shut. I had not been contacted in advance about this and I was startled by a sign on the front door which read that urgent work was being carried out to the floor of

the Centre. The floor was considered to be unsafe and it was not known when the work would be completed. The details of the nearest alternative Centre was provided. (Source: Reflective Journal).

I wondered to what extent the experience of being made to reapply for one's job or move Centre, without knowing what would happen next, was a more extreme version of the unsettling feeling I was experiencing at this time of general uncertainty regarding the future of the Children's Centre. I wondered whether the families arriving at the Centre would query the assumption that the Centre would always be open. I was also struck by the relevance of the floor no longer being safe; put another way the foundation of the building was unsafe.

By the time I was able to conduct my fieldwork interviews, a number of staff had left the team. The Head of Family Support, who was one of the founding members of the playgroup, had been moved to a different Children's Centre by senior management. This had occurred over a period of one month and had not only caused distress for the staff member and also contributed to a feeling of uncertainty about the future of the playgroup. Interviewing her soon after her move, she spoke retrospectively about her involvement in the work.

Alongside the changes to staffing there was the threat of the Centre closing, as part of a plan to reduce the number of Centres, which would become 'hubs'. For three months nobody knew which Centres would remain open and which would close. One might begin to formulate how the uncertainty of the future may have effected the staff group and created anxiety that was difficult to both process and to speak about in an interview. Stokes's (1994, p.121) work, in which he states that a "good old fashioned institution" is a rare thing, and that there is not the opportunity to "work out and work through the ambivalent feelings surrounding work that each individual has" is relevant to this institution in crisis. Stokes concludes that these "ambivalent feelings" contribute to staff anxiety that has to be managed in different ways. One way in which the staff managed their own anxiety was through retreating or a withdrawing into the imagined past.

Sure Start was an initiative of the Tony Blair/Gordon Brown years in Government. In 2010 a Coalition Government took office and cut funding to local authorities. The Labour Party has claimed that over 400 Children's Centres were closed as a consequence of cuts to local authority funding (Butler, 2013). The Government has responded by claiming, "that of the 401 closures, only 25 were what it termed "outright closures". The other 376 centres were reduced by reorganisations, including the merger of two or more centres. A census of 500 Children's Centres, carried out in 2012, had concluded that "many local authorities had tried to protect Sure Start funding, and Children's Centres were "a picture of resilience and creativity" (Butler, 2013).

Sure Start continues to be a politically contentious initiative. Changes to Children's Centres form part of the national picture, and are not specific to the institution in this research. It is the way in which some Centres are reported as having been saved through restructure that does not take account of the difficulties inherent in the reorganisation process and how this impacts on the staff and the work of the institution.

As the impact of change and uncertainty took hold of the playgroup, approximately six months of my arrival into post, it became more difficult to prioritise 'toddler development' Zaphiriou-Woods (2012, p.350) and consequently the aims of the playgroup were to some extent eroded. Staff were concerned about their own survival. The situation impacted on me in different ways. I was in a different position from the staff who depended upon the future of the Children's Centre, however I felt worried about the playgroup ending and wished that it would somehow remain running. I felt some responsibility to speak to staff and try to listen and engage with their experiences and to be available emotionally to what they might be feeling. I felt some feelings of guilt that I would leave at the end of the year, while others would remain within the institution, struggling to continue the work of the playgroup within the broader tasks of the institution, at a time when they felt unsupported.

My experience in the team: concluding remarks

There were aspects of the role that I found I could not offer, and then there were the anxieties I felt because I had arrived into the situation at a time of difficulty. It would be preferable for this work to be done by experienced Child Psychotherapists, not by those in training, and that the learning required to develop the role as a trainee needs special arrangements, including specific supervision and possibly mentoring. I did not have specific supervision for this work, and with hindsight it would have been potentially very helpful to have received this type of support.

My predecessor seems to have done a huge amount in terms of using her child psychotherapy capabilities and there was much to be continued and valued from her work in the playgroup.

The conclusions I draw from this research are (a) that the Therapeutic Playgroup was a valuable and valued model of work and (b) that Child Psychotherapists have the capacity to be very effective in work of that kind, and probably by extension in other open multi-professional settings.

The multidisciplinary work that I have described is increasingly what child psychotherapists are encouraged to participate in. Unlike other professional trainings, child psychotherapists can both work in a long term, open-ended way, and also offer brief time limited interventions. This suits the outreach model, which requires a flexible approach. A child psychotherapist can also work with just the child or with the whole family. Observation and play are important parts of the work, so that a playgroup is a suitable setting for the work.

I sometimes felt deskilled by not having immediate access to sleep advice and toilet training tips, which are frequently requested in this setting. I sometimes found myself thinking that if I were a clinical psychologist I might have more information available in the form of advice. When I did attempt to provide some kind of practical response I often found that it did not feel quite right either. I

could understand the requests made by parents as a communication of their need alongside feelings of helplessness and desperation for something that would immediately clear up the muddle of parenting. Knowing that it is not usually possible to provide this kind of immediate solution, and being comfortable with the reality of what is on offer and the value of it are all important lessons to learn.

I have found in subsequent work experiences that I have been more aware of what is needed to make this type of work successful, and awareness in itself helps. This goes back to my earlier point about the importance of experience, not just in terms of training, but also with respect to learning in a reflective way.

I think that the value of this research resides in the lived experience of the researcher. The research has aimed to convey what it feels like to undertake this work and how this work can be complicated by changes to the institution.

My predecessor described how she would provide:

> …A lot of translating really, trying to work out what we meant by things, and me trying to explain what I meant in a way that was, not just acceptable, but accessible to people who perhaps had very different views, or different backgrounds.

I think that what she conveys here is the importance of having a capacity to work on different levels, providing 'translation' to colleagues on subjects such as infant development and psychological processes in parallel to working with families. Being able to do this is perhaps a challenge best met when one has some experience of <u>not</u> needing to do this, of understanding about how to apprehend emotional life in a clinical setting without having to translate or interpret. In the words of Bion (1962), 'learning from experience' is key as it enables one to be able over time to rise to the varied challenges of outreach work and function in different ways according to the setting.

Chapter 5

Conclusions and recommendations

In this final chapter I shall summarise the findings of my research, and discuss a number of questions that arise from it, both in regards to the management and on going evaluation of an institution of this kind, and to the role that a child psychotherapist can usefully take in this type of work.

The study investigated the following central issues:

- the distinctive nature and value of this form of Therapeutic Play Group
- the particular contribution which a Child Psychotherapist can make in this setting (with all its difficulties)
- the impact of cuts and contraction on an innovative institution

Summary of the study

I decided that the most informative way of researching these issues would be to collect qualitative data to generate hypotheses and provide a detailed description of the institution. I interviewed the Therapeutic Playgroup staff using a semi-structured schedule of questions. Alongside continuing in my role within the team, I recorded my observations of the playgroup in the form of process notes and I wrote a reflective journal, recording my thoughts about the process of studying the institution. These methods of data collection took place over six months and generated a lot of information. I transcribed the interviews and I then applied a thematic analysis to the data.

Difficulties in carrying out the research came in different forms, such as threatened job losses and then actual job losses at the Centre. The difficulties became integrated into the study, with the interview schedule reflecting where the institution was in its' life cycle. I realised that it was important to include the difficulties which I encountered within the research because to some extent difficulties are inevitable and part of the process in outreach work. The Therapeutic Playgroup, in principle, was a valuable model of work which

became difficult to sustain when under pressure from cuts and uncertainty.

What is the distinctive nature and value of this form of Therapeutic Play group?

The specific and distinctive nature of the Therapeutic Playgroup is that it offers to families of young children specialist support and intervention, from a range of staff, to families who are unlikely to attend an appointment based service that requires a referral from a GP, owing to fear or suspicion of professional services or because of functioning in a chaotic and ambivalent manner in relation to services. The inclusive group set-up of the playgroup is designed to be welcoming to parents and children, but the priority is to focus on the development of the toddler. Historically, Therapeutic Playgroups have held the overall aim of supporting the emotional development of young children (Zaphiriou-Woods, 2010, 2012, Hoxter, 1981) and this particular example of the Therapeutic Playgroup follows within this tradition. However, it is a model of work that has been developed here with its specific community in mind, notably to engage with the Bangladeshi community of young families. The value in engaging with families when children are young provides an opportunity for difficulties to be worked with before they become entrenched or more severe.

Is there a specific contribution that the child psychotherapist makes in a Therapeutic Playgroup context?

The question of what a child psychotherapist can provide, which might be distinct or specific to the contribution made by other team members, emerged in reference to the work of my predecessor. The interview data suggested that a child psychotherapist could provide a reflective and integrative capacity, and an understanding of emotional experience. Significantly, these are capacities that can be applied in a consultant role with staff as well as in therapeutic work with families.

My predecessor provided a type of integrative function for the staff group in her capacity to think with and support staff members with their work. The commitment and length of time that my predecessor was involved in the work

were valued and highlighted by team members, as well as her approachability and other personal attributes which were conveyed as embodying something about the nature of the playgroup itself, a need to be invested and committed to the overarching aim of inclusion, early intervention/prevention and 'toddler development' (Zaphiriou-Woods, 2012, p.350). My predecessor was able to articulate her approach to the work, in terms of 'moving closer' to where the family might be, and engaging with the infant within the parent. Alongside this, she was able to provide 'translations' or ways of explaining how behaviour and states of minds in young children have meaning and can be understood as meaningful communication to families and to staff. This is comparable to Daws (1985, p.79) understanding of her role as 'consultant, standing by the weighing scales', and Cohen's suggestion that her role included 'articulating the experience of the baby' (2003), which might be described as the capacity to put into words complex emotional experience.

While other staff members expressed how much they valued the importance of play, the group setting, the structure of the playgroup and engaging young 'hard to reach' families, these reflective aspects of the approach to the work were mainly evident from my interview with my predecessor and the way in which she was discussed by her former colleagues. It is possible to think of these reflective skills, developed for example in the training of child psychotherapists, as applicable to other settings, such as schools and hospitals.

The difficulties of this type of work reside in the potential for a range of projections from different sources to impact on the setting, relationships with colleagues and with families. While this cannot be avoided in clinical settings, the structure of that situation of the work can be less chaotic, busy and complex than the contexts of outreach work. In the community, relationships with colleagues are of paramount importance and require nurturing and developing. These can most successfully be achieved over time and with experience that is unlikely to be available to someone still in a trainee position.

<u>How do the members of the team understand their contribution to the work?</u>

There was a difference between the way in which the family support group and the professional staff group understood and talked about their roles in the work. Professional staff members understood their role as being focused on working with specific families within the playgroup structure, often just parents initially, who had been highlighted to them by the family support team. They understood their work as being about helping families to feel less stuck or helpless, while simultaneously lowering expectations of 'magically' resolving families' difficulties. Some conflict was expressed in relation to the time-limited work which commissioners funded, and the reality of the complexity of the families using the service.

The family support team described their role as providing the initial link between families and the institution and within this, to the playgroup. This initial engagement required adequate containment of anxieties and suspicions about the professional staff members, usually perceived as potentially representing Social Care and Child Protection. Beyond this, the family support team held other responsibilities, including looking after children while their parents spoke to other staff members, and the clearing up and setting up the playgroup. There were a range of feelings expressed by the professional staff group about the ambiguity or changing role of the family support worker. The role was seen by some as not delivering enough to the work of the playgroup, or being too dependent on the individuals' talent or commitment. Some family support workers seemed to be thought of as superior to others. There was evidence of some unwanted feelings and ideas about failure and criticism having been projected into the family support group during a time of change.

A 'group' role was identified by some staff members, both professional and family support staff, which linked to responding to risk and child protection concerns, as exhibited within the playgroup. In these situations, the staff group took collective responsibility for making decisions. This is in keeping with Rose's

(2011) description of "collective preferences", enacted when the group prefers and intends to achieve the best outcome (p.152).

What was the impact of change and uncertainty on the staff contributing to the work of the playgroup?

There was evidence of considerable anxiety within the staff group in relation to the threatened job losses and changes. Some of these feelings were expressed in relation to restrictions in what became available to families, such as snack time. The other ways this was articulated was via a shift towards thinking about a nostalgic 'golden age' of the institution and discussion about the overall, broader institution, as opposed to the Therapeutic Playgroup and the specific staff changes and losses. This is in keeping with Nightingale and Scott's findings (1994) in relation to anxiety and change within institutions, and Menzies Lyth's work, which understood distancing and de-personalization as symptomatic of the mobilisation of defences against anxiety.

As more staff left there was less clarity about work distribution and the tasks of the playgroup, and a focus towards surveillance as opposed to reflective engagement took hold. It gradually became more difficult to remain working towards the long-established aims and tasks of the institution and playgroup of engaging vulnerable and deprived families and providing them with highly specialist care and support. The erosion of the overarching aims of the playgroup were replaced by anxieties surrounding survival. Despite this, the work of the playgroup continued throughout this period.

My journal data is relevant here in regard to how far it registers a serious decline in the quality of work. It may be that my observations, recorded in my journal, are telling a slightly different story from that of my interviewees. These different methods of gathering data were giving me somewhat discrepant information. It is possible that the staff, owing to the turbulent period of the playgroup, might have been applying a degree of splitting; which would help to

protect the 'good past' and the 'bad present', when in fact the reality was more complex and subtle, and much of the playgroup continued to embody good practice.

The lack of leadership function within the staff group was one of the most entrenched difficulties that the playgroup faced during my time in post. My impression was that the team was led by a group of individuals who provided a form of democratic leadership. I understood it that, in the past when the team had been functioning well, it held together through mutual trust and the facilitating work of my predecessor alongside a few other staff members.

Armstrong and Rustin (2011) have written about the development of ideas about democratic leadership, beginning in the late 1930s. The authors suggest two main arguments for the advantages of "consensual and democratic forms of leadership over authoritarian systems". (p.9)

> One concerns motivation and loyalty. Members of a work-group are more likely to commit themselves to its purposes where they feel valued […] The second argument concerns the links between innovation, complexity and uncertainty. (Ibid., p.9)

Armstrong and Rustin (2011) provide an example of a research department where outputs were "necessarily uncertain" and where contributions were made by employees with different expertise and seniority. They conclude that relationships had a stronger 'horizontal' element and that formal status hierarchies were weaker".

The structure of the staff group within the playgroup fitted with this description of 'horizontal' or 'lateral' relationships (Armstrong, 2007). My understanding was that, during a stable and functioning period in the institution's life cycle, there was a type of democratic leadership in place, which was provided by a number of individuals who felt loyal and committed to the aims of the institution and to outreach work. When a number of key staff members left, as a result of budget cuts and redundancies, the team commitment became fractured and the

individual ambition or loyalty to the institution became less of a priority, or a motivating force. The "collective preferences", according to Rose, (2011) are an important part of multidisciplinary good practice, perhaps comparable with "individual preferences" or 'hierarchical relations' (Garland, 2010), during times of change. There was evidence of professionals feeling more allied to or invested in their professional discipline or training rather than to the institution or the playgroup in which we all worked.

If a more adequate leadership function had been in place during the year I was in post, there might have been more opportunities to come together in an integrative way in order to think about the primary tasks of the institution and the future of the service. Without this function, the staff group was fragmented and isolated, and concerned more with individual rather than collective survival. I can see how my predecessor provided the foundations for integration and reflection within the institution. I am convinced that being able to contribute these qualities is one of the potential roles of the child psychotherapist.

Cameron et al (2009), highlight the way in which, while there can be a commitment to inter-professional working in Children's Centres, there are institutional obstacles to achieving the aims of collaborative work.

> Competing government agendas, insecure funding, a sometimes complex jigsaw of management and government structures on the same site were all obstacles getting in the way of inter-professional work. In the face of these difficulties, the co-location of services was not a sufficient condition for achieving good 'working together'. (p.5)

The Therapeutic Playgroup in my study was effected by many of these factors and collaborative working had become less of a priority, or less visible in the work of the staff group. The successful work that was achieved tended to be in the area of collaborative team-work. This suggests that there is a need to find ways of identifying and overcoming the obstacles to "working together".

Despite the changes, the playgroup and the Children's Centre survived the threatened losses and continued to function on a weekly basis, when other Children's Centres were closed. This is indicative of a model of work that was valued and felt to be working well enough, despite the challenges.

Questions of Evaluation and Accountability

The issues of evaluation and accountability create particular problems for an institution with the range of aims and activities that I have described. These issues are quite pressing for an institution like this, and for early years provisions more generally, with the current demand for evidence-based measures of output in all spheres of public policy. Some commentators, such as Polly Toynbee, argue for making these sorts of services universal as a necessary extension of the existing welfare and education system.

A distinction can be made between 'internal evaluation', and 'formal evaluation'. Internal evaluation refers to the way in which the staff, and the senior staff in particular, monitor the work of the playgroup; for example, who does what and what needs following up, and who has and has not attended. Formal evaluation is the need to provide evidence of outcomes for funders or public authorities. This open-ended approach is more difficult to record and analyse.

One way in which the Children's Centre part of the institution made sense of its own work and communicated this work to its users was to print termly paper timetables that were available at reception, and pinned to walls in the Centre. These provided a summary of what services were on offer and when they were available. This was an attempt to provide some information about the range of services available and to show the essential links between the community services provided and the variety of possible interventions.

This use of innovation and improvisation makes for significant difficulties in evaluation and the measurement of outcomes and effects. A report by Lord et al

(2011) highlights the limitations of the data collection in Children's Centres nationally. The following challenges were identified:

- The data is not sufficiently precise: data provided at a local/district level can be too broad and can, for example, mask the differences between an urban and rural area.

- Data sources are not drawn together. As one local authority officer said: "It's difficult, you've got about six different information sources on a family and it's getting that in one place so that everybody knows the same information".

- Different services (including health, social care and education) do not share information. It was evident across the case studies that trusting relationships went hand in hand with information sharing. In one case-study area, meetings were held regularly between Children's Centre managers and health providers, to share information about families and explore trends (2011, p.9)

This report reflects the challenges that all Children's Centres face in the collection of meaningful data. The focus of my study was a Therapeutic Playgroup that had not been set up to measure what was offered but to meet essential family needs which were not previously being addressed.

When the Therapeutic Playgroup was functioning well, with a leadership function in place, self-evaluation was effective, both in relation to families attending and activities. My impression was that this was not formally recorded but there was evidence of good self-reflective practice nonetheless, particularly in the meetings following on from the playgroup and the case notes. One example of this approach was the way in which it was possible to discuss the need to try to understand a child's tantrums, rather than to go along with the impulse to prematurely refer the family elsewhere.

Once the families had become sufficiently confident in the playgroup and at ease with the setting and with the staff group within the institution, a relationship could develop between staff and family. As a result of this developing relationship with family support workers and "front line" staff, steps could be

taken to refer parent(s) and child to the appropriate member of the professional staff group, where specialist work could take place.

Another aim of the playgroup was to help parents to change the way they might understand behaviour and to learn that children communicate through their behaviour. This, it was hoped, would move parents beyond a position in which behaviour deemed naughty or defiant is simply punished, and can instead be responded to and understood differently by parents.

The staff group interviews included many examples of the types of work done with families who fitted the description of 'hard to reach', in terms of domestic violence and substance misuse; examples of work done with refugee and asylum seekers who had traumatic histories, and with parents with chronic mental health problems. The examples included families leaving the playgroup, and then returning when they felt more comfortable or after having reflected upon their predicament with the staff group.

Being able to return, rather than be re-referred and wait to be seen again is a completely different model to clinic-based services. This model strikes me as being important for families who are ambivalent or find it difficult to seek help from professional services. There might otherwise be a time limited and restricted window of opportunity to engage with services, before ambivalence or anxiety prevents further contact.

A 'qualitative' approach in an external evaluation could include observation, and not merely audit by numerical outcome. The trained observer would be able to capture some aspects of the application of the therapeutic process. Observational material could convey some of the shifts and changes in the contact over a period of time between the service and family. Combining observations with a process summary from staff, such as the 'Family Journeys', that attempted to explain the process of an intervention, would produce a richer account of the work.

A report written by Cameron et al (2009) sought to investigate the factors involved in inter-professional working in schools and Children's Centres. By making comparisons with similar institutions in Sweden, the findings identified that within the English services the "concept of team was popular but elastic, tied to a sense of belonging to or identifying with the core purpose of the team". (p.3) This finding fits with the way in which the staff group in my study identified with the core purpose of the playgroup. The report highlights the short-term funding of initiatives targeting specific groups, including vulnerable families and children 'at risk'. It also referred to interviews with professionals who agreed that inter-professional work was important, but was rarely seen as a priority, nor were there many institutional strategies in place to implement it. It is from this type of comparative study, combined with studies such as mine, that a coherent picture about the effectiveness of work in Therapeutic Playgroups in Children's Centres can emerge.

Managing risk

Understanding how the team functioned in relation to the issue of risk has been a helpful aspect of this study. While I was a part of the team I was not able to process how compulsive and reactive this had become at times, and how this could threaten to overwhelm the initial contact with a family because of the fear and anxiety of 'missing something'. My child psychotherapy training has enabled me to bear 'not knowing' while using observation and counter transference, among other ways of working to build a picture of what might be happening. In crisis, the institution and staff needed to 'know' who was at risk and who wasn't. This might have been because of the uncertainty confronting the institution and its staff. One might even compare this with Nightingale and Scott's, (1994) study, in which it became evident that huge amounts of anxiety linked to organisational change had made staff deny their individual limitations.

It is difficult to recognise the risk phenomenon at the time because we all become infected with the anxiety of missing risk and being held personally responsible for failures. This quality of anxiety means that a type of 'blindness'

to risk can occur because the fear of culpability may lead to defensive assumptions being made that can cut contact with families. It is also tempting to keep a distance so as not to be responsible for truly 'seeing' what might be happening. Observing and being receptive to a young child's experience, often non-verbal, primitive experience, are part of a child psychotherapist's training. One begins to see the difficulties a mother or anyone else in a position of care might have in being able to bear being in close proximity to these primitive states. If one is able to help those working with children to develop a capacity to bear sensitivity to close observation, risk might be detected more effectively.

The ideal structure for enabling the sensitive detecting of risk would be a structure in which the team is able to talk about risk in a reflective way, without resorting to defensive blaming or premature action, and where the responsibility doesn't fall to one individual. The vignettes within the interviews that describe the possibility of continuing work with a family after Social Care referrals are made, suggest that this type of working did take place at some point in the history of the institution. From the examples provided by staff in their interviews, a picture emerges in which my predecessor was able to process the risk with the team and that this provided a level of containment for the staff group. It is possible that a work discussion group (Rustin, 2008) for the entire staff group might have allowed for staff to process their emotional responses to the work and for ideas to be shared and explored in relation to how the staff group might work together.

Based upon my experience of working in the team and conducting the research, I feel that when the playgroup was not under threat there was a high level of staff commitment to the aims of the work, but this was undermined to a degree when the playgroup came to be under threat. Overall, there were good relationships between the longstanding members of the group. Professional rivalries and tensions did not seem to interfere destructively with the overall aims of the work. Individuals coming into the team would often feel it necessary to assert themselves and their profession so as to be allocated referrals and to

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be seen as having something valuable to offer. I cannot over-emphasize the importance of the process of time in helping to make professional relationships work. I continue to reflect upon my predecessor telling me that it took "a couple of years" for her to work out "what I was doing." She remained in her post for a further seven years, which helps me to reach the conclusion that as Turner (1956, 1978) states, roles have to built and developed over time to fit the context.

Approximately one year after conducting the interviews, I emailed the participants to ask them how they had found the experience of the interview, whether it had been a helpful opportunity to think about one's work, or whether it had been a more complicated experience owing to the uncertainty surrounding the future of the work. A number of the staff group were no longer in post and the emails did not reach the participants. Two staff members responded. One staff member reported that she had "enjoyed" speaking with me. "It helped clarify some of my thoughts". The other staff member reported "I felt it was a completely open discussion and none of the questions were intrusive". I feel that this feedback suggests there is value in being able to have the opportunity to reflect on one's work and the contribution one makes to it, which one would hope a work discussion group would provide.

Further research

The model of the Therapeutic Playgroup has a large number of strengths inherent to it. It is a playgroup that attempts to engage and provide support to young families where there are difficulties, and attempts to contain and work with these difficulties in a setting that has been cultivated to feel welcoming. The group setting encourages a 'community' of families and helps children to meet other children as well as for parents to meet other parents. It is a situation that encourages parents to think about their children and to play with them and it is also a situation that attempts to socially integrate and include families who are members of ethnic or cultural minorities. With the appropriate amount of staff resources available there is a strong argument for an extension and

development of Therapeutic Playgroups in Children's Centres, as well as for the value of the role of child psychotherapists within it. Potential further research manifests in two different areas:

(1) There is potential value in researching and analyzing the complex situations in which child psychotherapists and others will be working when they move outside the boundaries of the consulting room, and seek to enhance mental health practices in a wider and more open environment. This example of a single case study shows how this work was done and the difficulties that were encountered. As discussed in the Methodology chapter, such case studies cannot easily be generalized.
Research into work of this kind needs the accumulation of more detailed case studies, so different are situations from one another, and so complicated are the interactions involved.

(2) It would be valuable to study the work of Therapeutic Playgroups like this one, and that of child psychotherapists within it, in conditions that were not as disrupted by external threats as the Therapeutic Playgroup in my study. Further research into Therapeutic Playgroups would help to assess the value of this model of work.

There is a need for there to be more linking up of child psychotherapists who do this work and there is a case for a workshop to facilitate this. With regard to the role of child psychotherapists working 'outside the clinic', there are many example of this work (Urwin, 2003, Jackson, 2002 and Daws, 1985). This work has increasingly come to be seen as part of the child psychotherapist's remit. Many of the developments in child psychotherapy have happened through 'research workshops' (Reid and Alvarez, 1999 and Kenrick, 2006). There is therefore a strong case for having a research workshop to develop work on this 'outdoor' extra-clinical work. It is a growth area that holds much potential for the future of child psychotherapy.

<u>My experience in this role</u>

Despite the limitations of how I felt my role developed in this service, there are a number of important learning experiences that I have taken from it and applied in subsequent employment. One of these is the importance of keeping a record of the complexity of the work. Often, there is a misconception that work in the community is less complex because it is less formal, or because it can be brief. I have been struck by how untrue this is. Often it was the more complex and challenging families who attended the service for a range of reasons, including it feeling less stigmatizing than a mental health service.

I think that this work has helped me to develop a more flexible way of working with families than is usual in a clinical setting. One needs to maintain similar professional boundaries to those needed in clinical settings, but also a way of communicating that is friendly and accessible and appropriate for the less structured situation. Holding in mind how daunting, shameful and unlikely the prospect of attending a CAMHS clinic or other service is for some families (Britton, 1981) means that I have become more aware of body language, my facial expression and tone of voice, as well as the language I use, and how all of these can impact of an initial meeting. Urwin (2003) similarly wrote that this type of work requires a modification of technique. Daws, (1985) has also discussed the struggle to position oneself in a place and in a way that neither feels intrusive nor invisible, and how difficult this can be at first. Being available and appearing approachable to both staff and families using the service, is an integral part of the work.

The process of carrying out the interviews and studying the data has made me think about the assumptions that staff members made about one another, such as the range of hopes and expectations surrounding the role of the family support workers. I think that if the institution had been in a more stable state, it might have been possible to process some of these ideas within staff meetings, or with the Head of Family Support and the Children's Centre Manager, and begin to unpack the way in which relationships between professional staff and

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family support workers could be better supported. Loshak (2007) writes how important it is for teams to have systems in which they are able to contribute to this type of dialogue. As it was, this wasn't a possibility for the institution, but in subsequent work I have been mindful of the tensions and projections that can manifest in equivalent relationships, for example between learning support assistants and school therapists. Trying to be aware of the way in which the lowest paid members of staff within an institution can become contaminated with projections from others about failure, lack of experience and other frustrations is an important issue to hold in mind when getting to grips with outreach work.

Recommendations

My recommendations to other child psychotherapists who might be beginning this type of work would be the following.

1. To understand the importance of time in the development of a role and in learning about the specific nature of the institution. The combination of what the institution wants/expects, versus what one can provide and develop over time is not a straightforward process and takes time to establish. This requires the capacity to bear 'not knowing' and to allow space and time for relationships with staff to develop.

2. To be assertive in saying no to responsibilities or requests that are being made, when it is not yet possible to understand the nature of the request, owing to being new to the team. For example, immediately taking on referrals might be tempting in terms of wanting to appear useful and busy, but during the early days of being in a post such as this much can be learnt from observing and being available and present in meetings, groups, and from talking to staff and hearing more about the work. Understanding the nature of the requests made of a new member of staff might provide valuable information about the way the institution functions, such as the request made of me to chair the meeting revealed a vacuum in a leadership function. Of course, this requires some

thinking and it is important to be available, approachable and committed to the tasks of the team while not rushing to premature decisions and commitments.

3. To contribute as much as possible to discussions about families/potential referrals. This will help to demonstrate to the team the way in which a child psychotherapist understands and thinks about children and relationships and how the infant or the child remains central to the thinking. This should inform others regarding potential referrals, as well as supporting staff members to make decisions about referrals and possibly, to help staff to understand their emotional responses to the work. Providing a containing function for difficult referrals or interactions with families to be processed and digested can be a valuable part of the role, but requires the building of relationships which allow for staff to feel sufficiently safe to speak about their work in an honest and reflective way. One might build on this work and move on to develop a work discussion group, in the tradition of Harris (Rustin, 2008) and similar to the work discussion groups developed by Jackson (2002).

4. The work requires a degree of 'thinking on one's feet' and managing the turbulence of changes that take place in teams and institutions. This can be compared to the process of psychotherapy, where engaging with the turmoil and difficulties within the sessions are inherent to the work and an essential component to helping to understand a child or a family. Just as clinical and indeed observational practice are learned, through individual and group supervision, so it is essential that supervision be provided to enable trainee child psychotherapists how to work well in community and institutional settings.

Finally, I hope this work may be found of value both as a contribution to the understanding of the practices of Therapeutic Playgroups shaped by psychoanalytic perspectives, and to the understanding of the role of child psychotherapists who may find themselves working in such settings.

Bibliography

Adelman, C. (1993). 'Kurt Lewin and the origins of action research', *Educational Action Research,* 1, (1) pp. 7-24.

Ahmed, J., Messent, P. (2000). 'MAP Project Progress report'. Unpublished.
Allen, G. (2011).'Early Intervention: Smart Investment, Massive Savings.'
Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61012/earlyintervention-smartinvestment.pdf
(Accessed on 4 May 2012).

Anderson, M. (1993). 'Studying Across Difference: Race Class and Gender in Qualitative Research', In Stanfield, J & Rutledge, M. (Eds.) *Race and Ethnicity in Research Methods'*. London: Sage.

Anning, A., Stuart, J., Nicholls, M., Goldthorpe, J., Morley, A. (2007). 'Understanding variations in effectiveness amongst Sure Start Local Programmes: final report.' London: Dfes.

Armstrong, D. (2005). The 'organisation in the mind': reflections on the relation of psychoanalysis to work with institutions'. In French, R. (Ed.), *Organisation in the mind: Psychoanalysis, Group Relations and Organisational Consultancy*. London: Karnac, pp. 29-43.

Armstrong, D. (2007). 'The Dynamics of Lateral Relations in Changing Organizational Worlds,' *Organisational & Social Dynamics* 7(2), pp. 193-210

Armstrong, D., Rustin, M. (2011).'What happened to democratic leadership?' *Soundings,* 50, Spring, pp. 1-13.

Armstrong, D., & Rustin, M. (2013). 'Revisiting the 'Unconscious defences against anxiety' thesis. Proposal for a research colloquium.' Unpublished paper, pp.1-19.

Arnold, C., Whalley, M. Lawrence, P., Peerless, S. (2012).'The voices of their childhood: families and early years' practitioners developing emancipatory methodologies through a tracer study,' *European Early Childhood Education Research Journal,* 20 (4) pp. 519-535.

Bain, A. (1998). 'Social Defences against organisational learning,' *Human Relations*, 51(3) pp. 1-20.

Big Lottery Fund Research issue 19. Healthy Living Centres three-year summary. (2005). Available at:
http://www.biglotteryfund.org.uk/er_eval_hlc_summary_yr3_uk.pdf
(Accessed on 31 July 2012).

Bion, W.R. (1962b). *Learning from Experience.* London: Heinemann.

Bose, R. (2002). 'Tower Hamlets Young People Substance Misuse Plan'. Unpublished internal document.

Boyatzis, R.E. (1998). *Transforming qualitative information: thematic analysis and code development.* London: Sage.

Braun V, Clarke, V. (2006). 'Using thematic analysis in psychology', *Qualitative Research in Psychology,* 3 (2) pp. 77-101.

Britton, R. (1981).'Re-enactment as an unwitting professional response to family dynamics'. In S. Box et al. (Eds.), *Psychotherapy with Families; An Analytic Approach*, London: Routledge pp.48-58 reprinted in M. Bower (Ed.) (2005) *Psychoanalytic Theory for Social Work Practice, Thinking under fire.* London: Routledge. pp. 169-181.

Britton, R. (1989). 'The Missing Link: Parental Sexuality in the Oedipus Complex', In Steiner, J. (Ed.), *The Oedipus Complex Today: Clinical Implications*. London: Karnac. pp. 83-102.

Burgess, R.G. (1984). *In the Field: An introduction to Field Research.* London: George Allen& Unwin

Butler, P. (2013). 'Hundreds of Sure Start Centres have closed since election, says Labour.' Available at:
http://www.theguardian.com/society/2013/jan/28/sure-start-centres-closed-labour
(Accessed on 23 July 2013).

Cameron, C., Moss, P., Owen, C., Petrie, P., Potts, P., Simon, A., Wigfall, V. (2009). 'Working together in extended schools and Children's Centres a study of inter-professional activity in England and Sweden'. Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/222043/DCSF-RBX-09-10.pdf
(Accessed on 31 October 2013).

Chamberlayne, P., Rupp, S. (2007). Sostris Stage Two Agency Study, 'Only Connect': Available at: http://www.uel.ac.uk/cnr/working.htm/GBBBBREP4.DOC
(Accessed on 10 December 2012).

Child Poverty Map of the UK, (2011). Available at:
http://www.endchildpoverty.org.uk/images/ecp/130212%20ECP%20local%20report%20final(1).pdf
(Accessed on 24 June 2013).

Cohen, M. (2003). *Sent before my time: A Child Psychotherapist's view of life on a neonatal intensive care unit,* London: Tavistock Clinic Series, Karnac.

Cohen, L. Manion, L. Morrison, K. (Eds.), (2007). *Research Methods in Education*, London: Routledge, pp. 186-254.

Craig, G. (2007). 'Sure Start and Black and Minority Ethnic Children'. London: DfES. Available at:
http://www.guardian.co.uk/uk/2007/jul/10/race.earlyyearseducation,
(Accessed on 10 December 2012).

Dartington, T, (2008). Obituary: Isabel Menzies Lyth. Available at:
http://www.guardian.co.uk/science/2008/feb/20/1
(Accessed on 6 September 2012).

Davis, S. Dewson, S. Casebourne, J. (2006). 'Maximising the role of outreach in client engagement.' Available at: http://www.employment-studies.co.uk/pubs/report.php?id=dwp326
(Accessed on 28 May 2013).

Daws, D. (1985). 'Two papers on work in a Baby Clinic: I. Standing next to the weighing scales'. *Journal of Child Psychotherapy*, 11(2), pp.77-85.

Department for children, schools and families, 'Sure Start Children's Centre, good for your child and good for you.' (2008). Available at:
http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@parents/documents/digitalasset/dg_172599.pdf
(Accessed on 28 June 2013).

Denzin, N. (1978). *The research act: A theoretical introduction to sociological methods.* New York: McGraw-Hill.

Donnelly, D. (2003). 'Let's face it - travellers need drug services", *Druglink*, July/August, 18 (4), pp.10-11. Available at:
http://www.savethechildren.org.uk/sites/default/files/docs/early%20years%20outreach%20practice.pdf
(Accessed on 8 May 2013).

Edwards, G. (2005). 'Sure Start: Public health success, or expensive failure?' *British Journal of Midwifery,* 13(10), pp. 628-630.

Every Child Matters, (2004). Available at: www.dcsf.gov.uk/everychildmatters
(Accessed on 4 January 2012).

Fielding, N. (1993). 'Qualitative Interviewing', In Gilbert, N. (Ed.), (1993), *Researching Social Life*, London: SAGE, pp. 135-153.

Garland, C. (2010). *The groups book: psychoanalytic group therapy, principles and practice.* London: Karnac, p.248

Geertz, C. (1973). 'Thick Description: Toward an Interpretive Theory of Culture,' In *The Interpretation of Cultures: Selected Essays*. New York: Basic Books, pp. 3-30.

Geertz, C. (1983). *Local Knowledge: Further essays in Interpretative Anthropology.* New York: Basic Books

Growing Together at Pen Green Children's Centre. Available at: http://childrenscentre.pengreen.org/research/short_course/growing-together/ (Accessed on 18 November 2013).

Harrison, B. (1993). 'Practitioner researchers in health care: an idea whose time has come?' Unpublished paper presented to the Annual Conference of the British Sociological Association, 'Methodological Imaginations', University of Essex, March 1993.

Head Start from Australia. Available at: http://www.ccypcg.qld.gov.au/resources/publications/headStart04.html. (Accessed on 3 January 2012).

Henton, I., & Midgley, N. (2012). '"A path in the woods": Child psychotherapists' participation in a large randomised controlled trial'. *Counselling and Psychotherapy Research: Linking research with practice*, 12 (3), pp. 1-10.

Hinshelwood, H.D, Skogstad, W. (Eds.), (2000). *Observing Organisations, Anxiety, defence and culture in health care*, Routledge: London.

House of Commons: Children, Schools and Families Committee, Sure Start Children's Centre's Fifth Report of Session (2009–10,). Available at: http://www.publications.parliament.uk/pa/cm/cmchilsch.htm (Accessed on 10 December 2012).

Holloway, I., Todres, L. (2003). 'The status of method: flexibility, consistency and coherence,' *Qualitative Research* 3 (3), pp.345-357.

Hoxter, S. (1981).'The old woman and the children who live in a shoe,' Unpublished paper.

Huffington, C., Armstrong, D. (Eds.), (2004). *Working below the surface: The emotional life of contemporary organisations*. London: Tavistock Clinic Series.

Hyden. M. (2008).'Narrating sensitive topics', In: *Doing narrative research*, Andrews, M. Squire, C. Tamboukou, M. (2008), London: Sage, pp.121-136.

Jackson, E. (2002). 'Mental health in schools: what about the staff?' *Journal of Child Psychotherapy*, 28(2), pp.129-146.

Kamaldeep, B., Stephanie, J.,Taylor, C.,Viner, R., Booy, R., Head, J., Tate, H., Brentnall, S. L., Haines, M., Hillier, S. & Stansfeld, S. (2005). 'Ethnicity, socio-

economic status, overweight and underweight in East London adolescents'. *Ethnicity & Health*. 10(2) pp. 113- 28.

Lawrence, W. G. (1985). 'Management development…some ideals, images and realities, In: *Group Relations Reader 2,* Ed. Colman, A., Geller, M. London.

Lewin K. (1958). *Group Decision and Social Change.* New York: Holt, Rinehart and Winston.

Lord, P., Southcott, C., and Sharp, C. (2011).'Targeting children's centre services on the most needy families' (LGA Research Report). Slough: NFER.

Loshak, R. (2007). 'There is a war going on! Someone is going to get killed!' *Psychoanalytic Psychotherapy,* 21(1), pp. 20-39.

Loshak, R. (2003). 'Working with Bangladeshi Young Women', *Psychoanalytic Psychotherapy* 17 (1), pp. 52-67.

Maiello, S. (2012). 'Prenatal experiences of containment in the light of Bion's model of container/contained, *Journal of Child Psychotherapy*, 38(3), pp. 250-267.

Mason, J. (2002). *Qualitative Researching*, 2nd Edition, London: Sage.

McGivney, V. (2000). *Recovering outreach: Concepts, issues and practices*, London: NIACE.

Meltzer, D. (1976). *Sincerity and Other Works: Collected Papers of Donald Meltzer* (Ed.), Hahn, A. (1984). London: Karnac.

Menzies-Lyth, I. (1959), 'The Functions of Social Systems as a Defence Against Anxiety: A Report on a Study of the Nursing Service of a General Hospital', *Human Relations* 13: pp. 95-121; reprinted in *Containing Anxiety in Institutions: Selected Essays, Vol. 1.* Free Association Books, 1988, pp. 43-88.

Miller, E.J., Rice, A.K. (1967). *Systems of Organisation: The Control of Task and Sentient Boundaries.* London: Tavistock Publications.

Miller, E.J. (1993). *From dependency to autonomy. Studies in organization and change.* London: Free Association Books.

National Head Start Association, (2012). Available from: http://www.nhsa.org (Accessed on 30th July 2012).

Neighbourhood Statistics, (2010). Available from: http://www.neighbourhood.statistics.gov.uk/dissemination/ (Accessed on 18 April 2012).

Nightingale, A., Scott, D. (1994). 'Problems of Identity in Multi-disciplinary teams: the self and systems in change,' *British Journal of Psychotherapy*, 11(2), pp. 267-278.

Perry, B.D, (2002), 'Childhood experience and the expression of genetic potential: what childhood neglect tells us about nature and nurture'. *Brain and Mind*, 3, pp. 79–100.

Pre-school Learning Alliance comments on OFSTED report on the early years, (2004). Available at:
https://www.pre-school.org.uk/media/press-releases/124/pre-school-learning-alliance-comments-on-ofsted-report-on-the-early-years
(Accessed on 20 July 2012).

Richardson, H. (2011). 'Closure threat to 250 children's centres'. Available at:
http://www.bbc.co.uk/news/education-12301690
(Accessed on 27 May 2012).

Riches, R. (2007). 'Early Years Outreach Practice'. London: Save the Children. Available at:
http://www.lancsngfl.ac.uk/projects/ema/download/file/ey_outreach_practice.pdf.
(Accessed on 2 May 2013)

Robson, J. (2007).'Reducing Health Inequalities in Tower Hamlets, Queen Mary University.' Available at:
http://www.enothe.eu/cop/the_bromley_bow_centre.pdf. (Accessed on 1 August 2012).

Rose, J. (2011).'Dilemmas of inter-professional collaboration: can they be resolved?' *Children & Society,* 25 (2), pp.151-163.

Rose, N. (1989*). Governing the Soul: The Shaping of the Private Self*, London: Routledge.

Rustin M. (2008). 'Work discussion: some historical and theoretical observations', In Bradley. J., Rustin, M. (Eds.). (2008), *Work Discussion: Learning from Reflective Practice in work with Children and Families*, London: Karnac, pp.3-21.

Salmon, G. & Rapport, F. (2005),'Multi-agency voices: A thematic analysis of multi-agency working practices within the setting of a Child and Adolescent Mental Health Service' *Journal of Inter-professional Care*, 19(5), pp. 429-443.

Scaife, J. (2010). *Supervising the Reflective Practitioner An Essential Guide to Theory and Practice*. London: Routledge.

Schön, D. (1983). *The Reflective Practitioner: How professionals think in action*. London: Temple Smith.

Steiner, J. (1993). *Psychic Retreats: Pathological organisations in psychotic, neurotic and borderline patients*, London: New Library of Psychoanalysis.

Stokes, J. (1994). 'Institutional Chaos and personal stress', In Obholzer, A. Zagier Roberts, V. (Eds.) (1994). *The Unconscious at Work: Individual and Organisational Stress in the Human Services*, Routledge: New York pp. 121-129.

Strauss, A., Corbin, J. (1998). 'Grounded Theory - An Overview'. In: Denzin, N., Lincoln, Y. (Eds), (1998), *The SAGE handbook of qualitative research*, London: Sage, pp.273-285.

The Tavistock Institute: History. Available at: http://www.tavinstitute.org/who-we-are/our-history/
(Accessed on 16 July 2012)

Toynbee, P. (2005) 'Dig deep to make Sure Start as brilliant as it can be'. Available at:
http://www.guardian.co.uk/politics/2005/jul/13/society.publicservices
(Accessed on 29 June 2012)

Toynbee, P. (2010).'Frank Field must not let the unthinkable happen to Sure Start.' Available at:
http://www.guardian.co.uk/commentisfree/2010/dec/03/frank-field-poverty-unthinkable-sure-start.
(Accessed on 26 June 2012).

Turner, R.H. (1956), 'Role theory,' In *Handbook of Sociological Theory*
Turner, J.H. (Ed.) (2002), Plenum Publishers: New York pp.233-254.

Turner, R. H. (1978). 'The role and the person,' *American Journal of Sociology,* 84 pp. 2–23.

Urwin, C. (2003).'Breaking ground, hitting ground: A Sure Start rapid response service for parents and their under fours', *Journal of Child Psychotherapy*, 29 (3), pp. 375-392.

Urwin, C. (2007). 'Doing Infant Observation Differently? Researching the formation of mothering identities in an inner city London borough', *Journal of Infant Observation*, 10 (3), pp. 239-251.

Ward, L. (2007).'Sure Start Failing Ethnic Minorities.' Available at: http://www.guardian.co.uk/uk/2007/jul/10/race.earlyyearseducation.
(Accessed on 10 November 2012).

Warin, J. (2007).'Joined-up Services for Young children and their families: Papering over the cracks or Re-constructing the Foundations? *Children & Society*, 21 (2), pp. 87-97.

Willig, C. (2001). *Introducing Qualitative research in psychology adventures in theory and method*, London: Open University Press.

Zagier Roberts, V. (1994) In**:** Obholzer, A Zagier Roberts, V. (Eds.), (2004). *The Unconscious at Work: Individual and Organisational Stress in the Human Services*, Routledge: New York. pp. 110-119.

Zaphiriou Woods, M. (2010). 'Preventative work in a toddler group and nursery'. *Journal of Child Psychotherapy,* 26 (2) pp. 209-233.

Zaphiriou Woods, M. (2012), 'From dependency to emotional self-reliance, the Anna Freud Centre parent-toddler group model'. In: Malberg, N.T., Raphael-Leff, J. (Eds.), (2012). *The Anna Freud Tradition: Lines of development, evolution of theory and practice over the decades*, Karnac: London. pp. 349-357.

Appendix I

Information sheet about the research

You are invited to take part in a research study, which we think may be important. The information which follows tells you about it. It says what will happen if you agree to take part.

You have been invited to take part in this research because you have contributed to this model of work

The goal of this research is to find out from talking to the different people who have contributed and worked together in this model of work what the experience has been of inter-agency, multidisciplinary ways of working.

In this interview you will be asked some questions about your experiences of working and contributing to this model of work, as well as other experiences of working with different professionals and clinicians, including working with a child psychotherapist. The interview will last for about 45 mins.

The research will hopefully be of benefit to the people who take part because if more is known about what constitutes a successful intervention or successful piece of work, than we may be able to do more to help the families that we work with. It is also an opportunity to reflect on your work. You will only have to attend one interview. If you become tired or decide you do not want to take part, or continue, you may tell the interviewer and the interview will stop immediately.

The interview will be tape recorded but all personal details will be kept confidential. For example your name will not be mentioned and the information that you give will be coded so that it is impossible to tell where it came from. Only the researchers/interviewer will have access to the interview material.

If you need more information about this study please do not hesitate to contact:

Supervisor of research: Dr ***** ***** The Tavistock and Portman Trust, 120 Belsize Lane, NW3 5BA, Telephone No: 0207 435 7111

You do not have to agree to take part in this study. You are free to decide that you do not want to take part, or ask to drop out at any time.

If you decide that you would like to take part, please fill in the attached form and give it to the interviewer. Thank you very much for your cooperation with this research study.

Appendix II

Participants' written consent form for the study:

Name (Block Capitals):

Job Title

Please read and tick all the boxes. Once you have done this please print your name, give your signature and put the date on the lines provided.

- I have been invited to take part in this research by the researcher.
- I have read and understand the information sheet which tells me about the research. I have a copy of this letter to keep.
- I have been given the opportunity to talk and ask questions about the study
- I understand that all personal information is strictly confidential.
- I freely consent to take part in the study.
- I know that I can withdraw from the study at any time.
- If I have any concerns I know that I can contact:

Supervisors' name and telephone number:

Name...

Signature...

Date...

Appendix III

Interview Schedule

Perhaps if we could start with you telling me something about the work that you do/did that is/was part of the playgroup?

What drew you into this work, it would be helpful to get a sense of how you became involved.

Could you tell me something about your history prior to this work, for example is this the type of work you have always done, if not, how is it different?
So to summarise at this point, you have worked here for…
You trained…

Can you tell me about how you think the team operates, so who does what, how the work is divided up, for example

From your experience, what kind of things does a family expect or want from this service?

How do families you work with tend to involve you?

What kind of requests are made of you?

Perhaps you could tell me about a piece of work that you particularly enjoyed, or felt happy about how it went? (further prompts might include, a particular family where you felt things improved?)

Is there something specific that you feel makes a piece of work with a family helpful or successful?

Have you worked in a multidisciplinary team or an inter agency team before? If so, in what way does this service differ or is similar to previous work experience?

How do you see your contribution to this work in relation to the other members of the team?

Has there been a piece of work or an intervention that hasn't been helpful or successful in your opinion? What thoughts do you have about why this might be the case?

What do you feel would be the important things for the researcher to hear about regarding the current changes and pressures on the team? Do you have any thoughts about the future of this provision?

How do you understand the work of the child psychotherapist in the team? For example, do you feel the work that a child psychotherapist does in this context differ from other team members? (Possible prompt, refer to my predecessor)

If you were to give advice or a tip to somebody from your training or background about this work, what would it be? (Prompt, provide an example)

Appendix IV

My interview: A vignette

Interviewer: Is there a piece of work or an intervention that wasn't so successful and any thoughts about why that might have been the case ?

Interviewee: Erm, I think tended to be families where there was a certain rigidity to what they were wanting and maybe a bit of a guardedness about professional services er, there were a few families who were introduced to me and I would try to speak and get to know, but I felt there was a real suspicion and a sense that they didn't feel able engage in any way that felt possible for the child to be thought about, they just felt quite closed and it was everybody else's ambition for them to be um seeing someone from CAMHS, or everybody's ambition for the child, because quite often the child would be presenting as quite needy, or er quite worrying, challenging behaviour, but the parent wasn't at a point where they felt they could begin to talk to somebody like me, even in an informal way, they weren't at that point and actually. Perhaps it didn't feel appropriate to be talking about their child in an informal group setting but perhaps they'd been in the privacy and the confidentiality of a CAMHS appointment, maybe they might have felt more able to, I don't know, maybe it would have been easier, if they'd agreed to a referral. But it was usually the families where it was the ambition of the Health Visitor and the Family Support Worker for the child to receive some support and the parent didn't feel able to engage.

UEL
University of
East London

MISS LAURA POLLARD
FLAT 16
7 LAMBOLLE ROAD
LONDON
NW3 4HS

Date: 15 July 2011

Dear Laura,

Project Title:	An Exploration into What a Child Psychotherapy Perspective Provides in Multidisciplinary, Multiagency Team Work Within a Children's Centre
Researcher(s):	Laura Pollard
Supervisor(s):	Cathy Urwin

I am writing to confirm that the review panel appointed to your application have now granted ethical approval to your research project on behalf of University Research Ethics Committee (UREC).

Should any significant adverse events or considerable changes occur in connection with this research project that may consequently alter relevant ethical considerations, this must be reported immediately to UREC. Subsequent to such changes an Ethical Amendment Form should be completed and submitted to UREC.

Approval is given on the understanding that the 'UEL Code of Good Practice in Research' (www.uel.ac.uk/qa/manual/documents/codeofgoodpracticeinresearch.doc) is adhered to.

Yours sincerely,

Merlin Harries
Research Degrees Subcommittee (RDS)
Quality Assurance and Enhancement
Telephone: 0208-223-2009
Email: m.harries@uel.ac.uk