What are my experiences as a Trainee Child Psychotherapist, setting up and facilitating a Work Discussion Group for clinical staff in a CAMHS setting.

Andrew Mc Gibbon

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ABSTRACT

This study reports on my experience of setting up and facilitating a Work Discussion Group (WDG) offered to the clinical staff of a Crisis Service in a Child & Adolescent Mental Health Services (CAMHS) setting. The research describes and analyses my experience of what it was like to offer a WDG in an established team that had had no provision of this kind previously.

A qualitative methodology was used, with the method of data analysis being Reflective Thematic Analysis (RTA), to analyse four significant sessions. The first session was the initial enquiry meeting with the Crisis Team and their managers; three direct WDG weekly sessions over the six-month intervention were also sampled.

Establishing a WDG in a CAMHS Team that already had a strong culture of its own was a complex but rewarding learning experience. The importance of letting experiential learning evolve in an intimate manner was essential and required curiosity to become alive in the WDG. In my task as a facilitator, I had to understand the Clinicians' defensive behaviour and for the Clinicians to feel understood and held without me becoming defensive. My training offered me a Psychoanalytic backbone to support new thinking within the WDG and to survive the initial feeling of hostility and rivalry from the Clinicians and lesser so from within myself. The WDG became more relevant after it had become established as it initially struggled to find a meaningful space within the CAMHS Crisis Team. The propensity for splitting and re-enactments due in part to the nature of crisis work was understood by moving beyond looking for logical meaning to bringing in thinking based on unconscious processes to add meaning to the clinical material that was presented. This added to the authenticity of the experience when discussing clinical material during each WDG session. In my experience, the WDG became a dynamic and authentic experience for the Clinicians. In my role as the facilitator, I needed to hold an internal experience in my mind of what a WDG involved in order for me not to get pulled into the busy culture of the CAMHS Crisis Team.
Keywords: CAMHS; crisis team; staff reflexive practice; psychoanalytic work discussion group

CHAPTER 1: INTRODUCTION AND SUMMARY OF STUDY

This study explores my experience as a trainee Child Psychoanalytic Psychotherapist of setting up and facilitating a Work Discussion Group (WDG).

1. See (Appendix A) for the complete acronyms list.

2. Whilst the subject of this study is my own experience, the clinical material comes from rich and dynamic encounters with Clinicians who offer Crisis Mental Health assessments and interventions within the Child & Adolescent Mental Health Service (CAMHS). The Crisis Clinicians can be the first contact Child/Young Person (C/YP) may have with CAMHS. The Clinicians generally have to manage mental health risks and do their best to ensure no additional harm comes to the C/YP. Generally, the network and family around the C/YP can be in crisis and struggling to understand and reflect on what has happened and how to move forward. It is often difficult for the networks around these C/YP to remain in contact with their experiences and think about how best to manage the Crisis.

In this research project, I wanted to hold the Clinicians in mind by offering a Work Discussion Group as an experiential learning experience. I wanted to analyse my own experience of getting the WDG established in The CAMHS Crisis Team and explore significant developments over the 25 weekly 75-minute sessions. I was interested in promoting the Ethos of a WDG as a place to gain additional meaning around some aspects of the Clinician's clinical work that they may be struggling to understand. This could involve their own emotional reaction to their clinical work as well as wondering about the C/YP emotional experiences. A WDG is not a supervision group, reflective practice group or teaching session. It may touch on certain elements of each of these areas, but it does have a set identity of its own.

During the psychoanalytic child and adolescent psychotherapy training, trainees predominantly work within CAMHS. It is part of the training to attend specialist workshops that last for one year on a weekly basis. I attended the specialist workshop on the psychoanalytic understanding of working with groups.

At a time when CAMHS are extremely stretched, I wanted to learn from my own experience if a WDG was of any benefit to a CAMHS Crisis Service. My interest in the subject of this study emerged out of my own experiences of supporting my own patients and Clinical staff who, when in or dealing with a crisis, benefited from my psychoanalytic training and my own experience of attending several WDGs. These experiences undoubtedly shaped my understanding and thinking about what may work in a crisis setting and my belief in the value of experiential learning. In undertaking this research project, I have sought to develop my understanding of my experience of starting a WDG and explore the complexities and the important possibilities it can offer the wider CAMHS network.

CHAPTER 2: LITERATURE REVIEW

This literature review aims to identify and discuss the most relevant literature to the research question. The particular questions I will focus on in this literature review are:

- What have other researchers' experiences been in bringing a group of professionals together for a WDG?
- What is the task of establishing and promoting a WDG in a service?
- What can I learn from a review of contemporary papers on WDGs that are not offered as part of a University course.
- What are the Professional experiences of working in a CAMHS crisis team?

The literature review will explore research on starting and facilitating a WDG within CAMHS or Child Care settings. In this review, I will be thinking about the research question from within the psychoanalytic paradigm as outlined in the research strategy. This review will not explore the comprehensive literature that discusses WDGs other than that WDGs who met to discuss their practice from within CAMHS and Childcare settings.

By conducting this literature review, I hope to become more sensitive to conducting a WDG with CAMHS Clinicians so that I can be better placed to develop my reflections on my practice and be better informed before I do my own study.

Literature review method

The review needed to have inclusion and exclusion criteria to make sure the study is systematic and appropriately targeted (Table 1). The literature review looked at the main themes of the research question as outlined in the research search strategy (Table 2). Given the complexity and the lack of space here to do justice to a full review of literature on WDGs, the researcher has narrowed the scope of this literature review to focus on papers most relevant to the study, namely: 1. Work Discussion Groups based on experiential learning. 2. The emphasis on psychoanalytic literature.

Inclusion and exclusion criteria

Inclusion criteria were developed to determine the appropriateness and quality of the studies found.

Table 1. Inclusion and exclusion criteria for literature search

INCLUSION CRITERIA	EXCLUSION CRITERIA
1. Papers are written in English	1. Papers not written in English
2. Papers discussing, exploring, or evaluating the Work Discussion Groups	2. Papers that focus solely on WDGs that have no mention of psychoanalytic concepts.
3. Papers focus on offering WDGs for childcare professional staff as a stand-alone WDG.	3. Papers which focus on WDGs which are not offered as a stand-alone WDGs, but are offered as part of a training program.
4. Papers offered within the "learning from experience" ethos of WDGs.	4. Papers that didn't appear to be offered within the ethos of WDGs with a total focus on teaching with no evidence of any emotional reflections within the WDG.

Databases used

The literature search used a range of relevant databases available through the Tavistock Library: CINAHL, Psychology and Behavioural Sciences Collection, PsycBooks, and the Education Source and Education Resources and Information Centre (ERIC), PsycINFO, PsycARTICLES and PEP Archive.

Search terms

I will carefully identify the best search terms to capture each central concept and comprehensively search for the most relevant literature. This included truncating words which may have different endings (e.g. Psychotherapis* to cover Psychotherapy and Psychotherapist) and cross-checking this within the keywords of the most relevant papers which emerged.

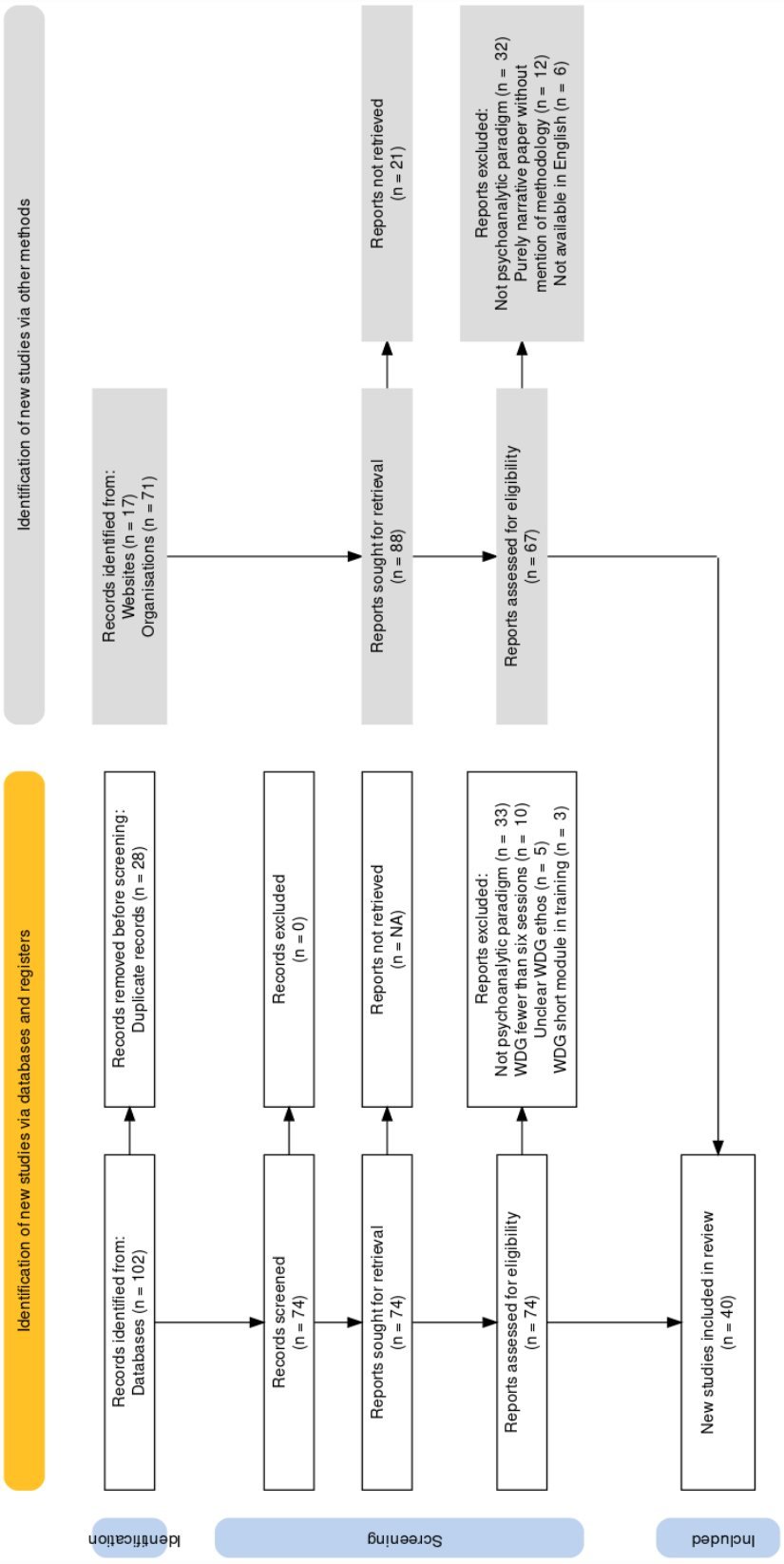
Table 2. List of Boolean search terms used in the literature search

Research question: What are my experiences as a trainee child psychotherapist, setting up and facilitating a work discussion group for clinical staff in a CAMHS setting.		
S1	Work Discussion	'Work Discussion' AND 'Group' OR 'Seminar'.
S2	Setting up	'Setting up' OR 'starting'.
S3	Trainee Child Psychotherapists	'Trainee Child Psychotherap*' (to include 'Trainee Child Psychotherapists' and 'Trainee Child Psychotherapist' and 'Trainee Child Psychotherapy')
S4	Child & Adolescent Mental Health Service	'Child & Adolescent Mental Health Servic*' (to include 'services' and 'service') OR 'Child and Adolescent Mental Health Servic*' (to include 'services' and 'service') OR 'CAMHS'

Selection process of papers for review

This selection process is outlined below in the PRISMA flowchart in Figure 1. When I used my search terms, I found a large volume of literature that did not appear to be rooted in the psychoanalytic tradition; although interesting, they were not directly related to my study. Several studies focused on WDGs that were often for less than six sessions and did not offer an in-depth analysis of their methodology. In other studies, the term WDG was mentioned but did not fit with the ethos of experiential learning and was more focused on the seminar leader's teaching as the expertise. Finally, other papers focused on the WDG as a part of a more extensive educational course. Although interesting, they were not stand-alone WDGs; these WDGs primarily provided an opportunity for participants to reflect on other elements of the broader course, for which a WDG was just one module.

Figure 1. PRISMA flowchart outlining the literature review process and outcome



A brief introduction to Work Discussion Groups

The majority of prior research carried out used case studies to demonstrate the role of WDGs. Most of the studies focused on supporting frontline professionals involved in working with vulnerable children. This dates back to the first Work Discussion Seminar Groups, which started as a method of enquiry into working with children. These WDGs were not directly run for children to attend but were aimed at working with professionals who worked with children. Mattie Harris (1967), as quoted in Klauber, T. (2016), was one of the first people to introduce this approach of inquiry at the Tavistock Clinic when she brought together small, diverse groups of people interested in their work with children. These early Work Discussion Seminar Groups looked beyond the children's words and actions, aiming to understand their communication at a deeper level. A psychoanalytic lens was used to try to understand what may be behind the words and actions of the child. The professional's own feelings around their work were also thought about. This simple thought of a group of people getting together to think about their work with children has developed over the last 53 years, as has its flexibility to be used in different settings. My review of the literature shows that the WDGs offered today still have a lot in common with the work of Mattie Harris (1967).

The current papers on WDGs all have one thing in common; they build on clinical work from the past with their roots in the psychoanalytic tradition. The contemporary WDG studies I reviewed have been tasked with addressing different needs in diverse systems; these papers are mainly case studies. I will not be providing an in-depth overview of WDGs, which is beyond the remit of my study. The literature review was narrowed to focus on what several authors have written on setting up and the facilitation of Work Discussion groups in a diverse range of settings. The majority of the authors are not talking about some abstract concept that they are giving an opinion on. Instead, they are writing from an experience of their own practice as either having attended or, in most cases, facilitated a series of WDGs. Most of the papers I reviewed have been born out of these clinical experiences. This experience of writing in a case study style appears very widespread in the literature I reviewed on WDGs.

My experience of the literature is that WDGs are not restricted to being delivered in only one type of environment. For example, they can be offered as part of a Master's

level educational program, such as courses offered by the Tavistock & Portman NHS Foundation Trust and the Anna Freud Centre. Within these settings, members typically come from different work settings, but the common thread is attending the course; this is predominantly a group of childcare professionals who generally have never met before enrolling on the course. They may have similar professional backgrounds and work settings, but as a group, they have never been all together before starting the course. This has its own challenges; as Klauber (2008) in Murray (2011) highlighted, it can be difficult for experienced professionals to attend a WDG. This can be that they have to think about their own well-established ways of working, and it can be a challenge to create emotional and intellectual room for new learning. The second type of environment is where the WDG is offered as a stand-alone experience, such as what I am going to offer to the CAMHS Crisis Team. These are the two main different settings that WDGs can be offered. A very influential book called Work Discussion: Learning from Reflective Practice in Work with Children and Families (2008), edited by Rustin & Bradley, brings together a vast amount of studies written by a diverse range of professionals in different settings within the book. This book was a significant coming together, focusing on the nature of the learning within WDGs**.** This book brings one into the fascinating history of the developments within WDGs. Waddel (2008), in her introduction, gently spells out the methodology that characterises work discussion. Klauber (2008) uses rich examples of people's reactions to being a part of WDGs. She talks about the model of Work Discussion, which recognises the worker's own experience and attempts, through the group's work and the support of a psychoanalytically trained seminar leader, to reflect and create deeper understandings through focussing on the work and role of the professionals involved. Klauber's (2008) sees this kind of understanding as having a transformative effect on its members. I would have liked to have heard more detail about these transformative experiences. She insightfully advises against the dangers of the WDG crossing into a personal therapy group.

Bradley (2008) cautiously warms about a WDG turning into a clinical supervision group. Containment and active listening are mentioned in lots of places in the book. Bion's (1962) concept of containment being related to the experience of the facilitator containing anxieties within their role and task. Rustin talks about being careful that the WDG does not become a theory-focused experience and losses its focus on

experiential learning. Agent's (2008) writing in the book highlights developing an observational stance in order to add greater detail to clinical material used as a write-up to present during the session; her writing was helpful, practical, and easy to digest. Jackson (2008) expands one's mind to the flexibility of the WDG's approach by stepping into the world of education and helpfully brings alive the teacher's experience of the complexities of what can happen within a school environment and how teachers can be supported with a WDG. Unfortunately, the next chapter, which was written with a focus on several case examples by different authors, confused me, and I found it hard to hold the structure of what was taking place within the different group examples. A strength was that it was evident that psychoanalytic thinking was valued within the different settings, but I did find this a complicated chapter to read. The next chapter I reviewed was on the international application of WDGs, this chapter was exciting, and the dilemmas were well explained in practical terms. The chapter on setting up the WDG in Naples was practically focused and linked well with my research question. The need to take care of the detail of the setting and a consistent approach was very strong in this chapter. I found Williams writing inspirational, and her conviction was contagious; in a way, it helped strengthen my belief in the WDG method. In general, the book talked about the seminar leader's active role in defining and sustaining a non-judgemental climate of curiosity and hope and maintaining focus in the group. Looking through the psychoanalytic lens was encouraged. To sum up, noticing interactions and observations are encouraged, as are discussing these experiences within the WDGs, and, in these conditions, insights may emerge. It is a fascinating book, if not in one chapter confusing, because of the individual styles of some authors.

Contemporary Papers on WDGs

One of the more contemporary papers I reviewed was by Klauber and Jackson (2018); this paper was entitled "New developments: training in the facilitation of work discussion groups". It concentrates on delivering a short five-day training program on the use of WDGs. There is an evaluative feel to their writing which is refreshing. Their paper captures the broader experiences of how members experienced what a WDG has to offer and involves. In addition, one of the aims appeared to be focused on training up the participants to deliver a WDG. I found this aim somewhat a little

ambitious as the participants appeared to have no psychoanalytic training, but this article was testing the boundaries of what a WDG could offer. The authors describe their experience of developing a pilot five-day foundation course in Work Discussion Group facilitation. The participants on the course appeared to be unfamiliar with the Work Discussion Group model. The job of containing the group and keeping it on task was carefully thought about while taking note of unconscious processes and powerful projections of anxiety and inadequacy, which dominated the members as they started to present their own material in the WDG. The facilitator's role as a container of projected anxiety was highlighted as a core task. The pull from the participants to draw the facilitators into didactic teaching was interesting and helpful. This led to more thoughts of how the facilitators could be stirred into enactment when projections from the group or the subject of the presentation get projected into group members and invite the facilitator to be pulled out of the role. The participants clearly felt supported by the teaching style of open curiosity. I also liked the way the facilitators built a reflective space for themselves into the program. The facilitators indicated that the course had a powerful and transformational impact on many; some went on to introduce work discussion into their own work settings and to research it. This was more of a descriptive statement, and more analysis of these experiences would have been interesting to read about in more detail. Nevertheless, this study helped me think about my own study and the dangers of acting out of projections.

The next paper I reviewed was by Zacharia (2020), entitled creating a link between CAMHS and children's centre in a deprived area. The paper has a helpful, practical feel to it and interested me as it was a case of setting up a WDG. This thesis explores the process of setting up a WDG and fits in well with my area of research. In that, we were both trying to give birth to a new experience within an established team. It focused on starting a Child Psychotherapy-led outreach service in a Children's Centre in a deprived urban setting. The author interestingly uses a WDG as a starting point towards engaging frontline workers to think about the early signs of mental health problems in their client group. Interpretative Phenomenological Analysis (Smith et al., 2009), coupled with a psychoanalytic understanding, was used to shed light on the lived experience of the participants in this project, and the detail of the analysis is good. The author draws attention and thinks about the importance of the environment in which the WDG is offered. This awareness about the environment and culture felt

like an extremely important point. Zacharia sees the Children Centres as being containers for significant children and parental anxieties. In this paper, the author focuses on a WDG as a gateway to helping workers think about deeper emotional issues. This WDG has a focus, and in line with existing literature, the study highlights the importance of time and a consistent 'therapeutic presence'. The WDG facilitator and participants go on to think about the power dynamics that give rise to unconscious attacks, splitting between good and bad services and the impact of paranoid anxieties and lack of trust that can occur as part of the process of trying to come initially together within a WDG. The author suggests that the Children's Centre staff could benefit from working closely with Child Psychotherapists and participating in WDGs on a regular and voluntary basis to equip them better to think about children's emotional states. I would have liked to have learnt more about how the group was structured and how the group developed, as I was left confused about what took place and wondered if there was a crossover in this paper between a focus group and a WDG.

Moving to another paper focused on WDGs written by Moore (2018). This paper is called "Work discussion as a method for supporting peripatetic teachers of vulnerable children". Moore's paper is thought-provoking as she brings a group of teachers together who spend large amounts of their professional lives working in isolation with vulnerable children in a non-traditional educational setting such as the children's own homes. This WDG has a sense of having a place to connect with other teachers, almost in a way replacing the teachers' staff or meeting room. This feels extremely important but even more so because of Moore's understanding of her colleagues and how she brings this sense of herself to add to the atmosphere in the WDG in her role of the facilitator. Moore argues that the WDG offers a place of stability in the chaos that surrounds these teachers. Moore (2018) sees the WDG for teachers as a place to offload their frustrations and gain support. It provides the opportunity for teachers to understand the children they teach and improve their practice when they can manage to reflect.

Moore talks about her own experiences of this WDG was at The Tavistock Centre for two years; this experience appeared to motivate Moore to introduce a WDG into the system where she teaches, and this being an invaluable experience and learning curve. This mainly was around the facilitator role as being a new venture which she thoughtfully reflects on. She talked about her own frustrations and feeling impatient

when members got caught up in talking about resources, lesson plans and exams. Over time, Moore reflects on her experience and sees herself as learning to be patient and acknowledges how hard it is to reach a reflective state of mind in the group—also talks about her own experience and its challenges, which brought a sense of realism to the paper. Moore argues that the practitioners could take something in from the discussion that changed the way they took up their teaching roles and how they related to the children. Moore makes the interesting point that different members go at different paces, and work discussion as a method for supporting teachers is flexible and allows individuals to explore their experiences. Moore reports that everyone who attended used the group as best they could, even if, along the way, there were only glimpses of the promised land of reflective practice. I found this paper very helpful and well-written paper. Despite the challenges, a sense of aiming the WDG at an unmet need was welcomed with open hands by the teachers. This paper helped me think about the nature of timing and making space to let a WDG grow.

The following paper that caught my attention was by Hover-Reisner (2018), “Holding mind in mind the use of work discussion in facilitating early childcare (kindergarten) teachers’ capacity to mentalise”. It started with placing great importance on the write-up for the WDG session as a helpful tool for focusing, and the detail of this study reminds me of Agent’s (2008) chapter in the book “Work Discussion” (2008) for its attention to presenting a detailed write-up to present in the WDG session. Its centre focuses is on discussing aspects of work discussion that promote Mentalisation (Allen 2006).

This paper promotes the use of reflective space and links it to mentalisation in line with the process of reading through one’s own material and reflecting on it as part of a WDG. The authors are experienced practitioners in the delivery of WDG’s. They see mentalisation almost as a natural development of what goes on at the core of a WDG. In doing so, this encourages a new understanding of the emotional aspects of the work. It was a valuable paper to read and promoted the positive use of WDG’s and demonstrates the flexibility rooted within the work discussion group tradition, and has a strong focus on thinking about the emotional aspects of the work.

It is clear from reading this material that this is a WDG used for metallisation as to a metalisation group used as a WDG. The simple task of remembering, visualising,

and writing down what happens is brought into the conversation. The author brings the complexity of the WDG alive in a simple language. This stimulates processes of reflection on the self and others on a conscious and unconscious level. The paper reports that the mere process of remembering and writing down a specific situation sets processes in motion that are related to understanding the emotional significance of behaviour. This paper adds some important overviews on the internal working of the WDG. For example, when reading the report aloud in the seminar, importance is attached to the account. They are directed to visualise themselves the feelings in the situation described. This stimulates the process of self-reflection. Reading out loud confronts the seminar leader and the other seminar participants with the situation, who then develop thoughts, feelings and fantasies about the behaviour described as well as about the emotional concerns of the people involved in the situation. While discussing the material that was presented to the group, the seminar members can participate in the explicit mentalising of the group leader and other group members and, in doing so, the participant's experience that it is possible to reflect and talk about feelings. I found that this paper, in places, was talking to an audience that had prior knowledge of what a work discussion group involved. The facilitator call's upon the participants to search for evidence for interpretations of events in the account. This task encourages the practitioners to mentalise explicitly, which in itself is interesting, but I was unclear about what exactly the author's of the study meant by mentalisation and was it much different than developing an observational stance. In the process, the seminar leader consistently tries to maintain an 'emotional climate' in the group, which they view as being vital for encouraging mentalisation ability in a pedagogic context. When discussing accounts, the seminar group functions as a mental space that offers holding (Winnicott, 1965) and makes it possible to reflect on relationship processes that were, at the time, more difficult to think about. The author writes that continual participation in work discussion seminars enables participants to be increasingly capable of grasping mental states, putting them in words and discussing them, as well as reflecting on these presumed mental states with the group. Consequently, the authors appear to assume that the experiences gained during the work discussion seminar also stimulates implicit mentalisation and will lead to a mentalising attitude. By doing this, the author's stated this enables practitioners to reflect as they work and to

> "be open to the inner events of others, to let them influence us, to absorb their points of view and to allow ourselves to be thus encouraged or persuaded to think, feel and act better" (Allen, 2006, p. 49).

I found this paper very technical and aspirational, and I was a little overwhelmed as I wondered if these marvellous experiences would be achieved in the WDG that I was going to offer to the Crisis Team.

Moving onto Trelles & Fishman's (2019) paper is called: "Towards emotional containment for staff and patients: developing a Work Discussion group for play specialists in a paediatric ward". The paper superbly focuses on the unconscious process that takes place in a WDG, starting with the development of the trust that allowed its members to bring themselves to the group in a genuine, open way with the aim being to find support. Focusing on the workers' capacity to process, reflect and think their work through is in part a reflection of the work that goes on in the group and links in well with the previous paper. Trelles & Fishman sees the key element in making this work possible resides in the unspoken qualities of the atmosphere in which the discussion takes place, which is emotionally containing, as described by Bion (1962). Put simply, but exceptionally important in my eyes, is the group's 'reverie' Bion, (1962). These qualities are trust and a genuine interest in what is said, a sympathetic attitude, and the effort to understand and involve oneself in the discussion. Hearing about the pain, knowing about it through holding it in the group's mind and being able to reflect on it, as Bion proposes, is what allows us to process our experience in a way that makes the work more bearable and helpful.

Research around a CAMHS crisis team

I wanted to review the literature related to CAMHS Crisis Teams. Within the National Health Service, Child & Adolescent Mental Health Service (CAMHS), Crisis Teams work with C/YP experiencing significant mental health difficulties and have presented in a Mental Health Crisis. These CAMHS Crisis Teams can offer short-term intensive and frequent (often daily) support either in a clinic or home environment. In order to gain an understanding of previous work carried out in this area, the extensive

literature reviewed produced limited closely related material and involved several different search formats until I felt I had exhausted all avenues. I also was somewhat excited to find limited information as I felt this increased the value of my area of research. I hoped to find some studies that talked about staff's experiences of working in a CAMHS Crisis team.

Previous studies by Halsey (2014) examined the prevalence and predictors of burnout and secondary traumatic stress (STS) within CAMHS staff across Tier two, three and four services. Consistent with previous studies conducted within CAMH teams, emotional exhaustion levels were at the higher end of average and significantly higher than the normative data of mental health professionals within these groups. Emotional exhaustion was predicted by high levels of perceived stress and low levels of perceived organisational support. I was partly aware of this, at least on a conscious level, having worked in CAMHS for the last 14 years as a Senior Social Worker and seen many of my colleagues leave or go on long-term sick leave. However, I thought Halsey's study lacked detail in some areas. I felt the focus on seeing the practitioners as needing additional support was more a micro issue and would have liked it balanced more by considering macro issues around how the system may impact the practitioners. I would have liked to have learnt more about the cultural aspects of the CAMHS services. Education around symptoms of burnout and STS and Acceptance and Commitment Therapy-based interventions were suggested as potentially beneficial for increasing personal accomplishment and improving staff well-being.

The nearest studies I could find in relation to Crisis services talked more about the opinions of the C/YP and families who used the Crisis service. These two studies by Staite (2020) & Vusio (2019) talked about the important role of a CAMHS Crisis team but did not provide any significant details about the workings of the service, the structures or the organisational context of the teams or anything in relation to the Clinician's experience of offering the service.

The following paper is indirectly related to my Research Question. This paper does set the work in the context of where I will be offering the WDG. The paper is by Staite (2020); this paper evaluates a young person's functioning following a mental health crisis and the outcome of an intervention from a CAMHS Crisis Team in the North of England. The paper entitled "How well do children in the North East of England

function after a crisis: a service evaluation*"*. This study reported that an increasing number of young people in the UK need access to mental health services, including Crisis Teams. The findings showed that no patients significantly deteriorated in functioning after accessing the crisis service. "The Practical implications were that despite a possibly overly conservative analysis, 15% of patients not only significantly improved functioning but were able to return to a healthy level of functioning after a mental health crisis with support from a CAMHS Crisis Team" (Staite 2020, p. 162). This paper allow interesting could have been improved if it offered a more in-depth analysis of the data.

Another related paper on crisis interventions was written by Vusio (2019). They identified 19 studies that were divided into four domains: alternative models, C/YP parental satisfaction, and experiences of accessing urgent and emergency mental health services. The findings showed that alternative models to inpatient or acute settings might be a feasible substitute for some C/YP. The author found that C/YP had increased satisfaction with alternative models in comparison with care as usual. However, parental feedback data identified high levels of parental burden and a range of complex emotional reactions associated with engagement with crisis services. Importantly, both parental and C/YP experiences highlighted a number of perceived barriers associated with seeking help from crisis services. However, it is clear from the results of this systematic review that there is a need for further research to understand what constitutes appropriate interventions and treatment for C/YP experiencing a mental health crisis. Unfortunately, I found this paper to be unclear about what a crisis service can offer and how it should be offered in a robust and planned way. However, it recognised that barriers to seeking effective crisis care do exist with the loudest protest coming from the parents, which would have been interesting to explore in order to get a fuller picture. I wondered whether the C/YP voice was lost by the sound of protests from unhappy parents or carers. However, this paper was helpful in preparing me as it highlighted difficulties for parents and C/YP in a mental health crisis and the helpful containing function of these Crisis Teams.

CAMHS Crisis staff stressors and secondary trauma

The emotional experiences of Clinicians who have been asked to try and contain the complex needs of C/YP in a mental health crisis could be challenging. Once again, I found it difficult to find papers directly related to my research study, but I did review several helpful papers that added to my knowledge base around group processes and the impact on Clinicians of working with C/YP who have been traumatised.

At assessment, the C/YP may convey their plight powerfully, giving the Clinician a condensed experience of the desperation or the dilemmas they are struggling to manage. Weegmann (2002) has written about the possible dynamics and pressures of the 'first meeting' and how the individual may project out their suffering, inviting the Clinician to know what life is like in their shoes. The paper by Miller &Rollnick (1990) argues that finding the right words to express empathy and understanding is not easily acquired and can be difficult if the patient is in a disturbed state of mind. Weegmann (2002) suggests that a C/YP will readily assess a Clinicians' level of experience and spot the Clinician who is simply going through the motions. Miller (1990) discusses how complex defences come into play, such as a disavowal of the consequences of the actions; Clinicians may have to help the person acknowledge the seriousness of their situation while maintaining a message of optimism that such problems can be addressed. Miller &Rollnick (1990) helpfully bring up the issues of defences and how the clinician's best attempts to reach the person in distress can be rejected.

> "The clinicians attempt to reach the C/YP's vulnerabilities but face the defences that have formed a protective shield around the dangerous behaviour. Very often, the Clinician is fought against since s/he represents change". Miller & Rollnick (1990, p. 67).

CAMHS Crisis Clinicians are regularly exposed to trauma and distress; this is when working with C/YP who have had traumatic experiences or with families in despairing situations who have been affected by trauma (domestic violence, parental mental illness) or distress.

> "The emotional impact of working with children may occur directly as a result of the challenges of managing behavioural difficulties or indirectly through hearing about a child's traumatic history". Meyers & Cornille, (2002, p.18)

Working in a CAMHS Crisis service brings one into close contact with C/YP, who have generally had a difficult experience that has emotionally overwhelmed them. Perry (2006) described traumatised children as being in a constant 'state of alarm', even when no external threats are present. Perry (2006) emphasises that traumatised children can also perceive adults as 'potential sources of threat' rather than sources of support and comfort.

Part of the Clinician's role requires trying to be emotionally attuned to the C/YP world, but this can be emotionally depleting, sometimes with little recognition of the complexities of the job, especially if the child is in a traumatised state of mind. Janoff-Bulman (1985) discusses the impact of working with people with trauma and suggests these experiences shatter three basic assumptions held by Clinicians, a sense of invulnerability, belief in a meaningful world and positive self-perception. When I first looked at this paper, I was not surprised but uncomfortably reminded that there can be a personal cost to one sense of self, and for me not to be aware of these issues when running a WDG for the crisis team would be naive.

> "The potential impact on the Clinician's state of mind can trigger experiences of unsafety, lack of trust, powerlessness, and loss of professional esteem, fear of intimacy, independence, and control". Pearlman & Saakvitne, (1996, p. 62)

These vulnerabilities make Clinicians feel unsupported and could result in secondary trauma, which could impact the function of the WDG. Secondary trauma is now a widely recognised phenomenon and concerns the negative psychological effects of indirect exposure to traumatic material upon the helping professionals trying to help people in distress. According to the trauma specialist Figley (2002), the symptoms of secondary trauma are almost identical to those associated with post-traumatic stress disorder (PTSD); the only difference is that the PTSD symptoms are directly related to the sufferer, and secondary trauma symptoms are a result of

"…..exposure to knowledge about the traumatising event". Figley (2002, p. 143)

These issues discussed by these authors have a practical application to their papers and could be very alive in the WDG, and as a facilitator, I would need to be aware of asking clinicians to think about their work and think about possible emotional triggers that could cause distress in the WDG in an uncontained way.

> “The symptoms of secondary trauma include anxiety, disconnection, isolation, avoidance of social contact, becoming judgmental, depression, somatisation, and disrupted beliefs about self and others. This can result in finding it hard to concentrate or listen to more distressing stories and difficulties managing boundaries between work and home life”. (Pearlman & Saakvitne, 1995, p . 186).

Secondary trauma impact is emotionally, cognitively, and behaviourally (Bride, Radey and Figley, 2007), taking its toll on the psychological resilience of the ‘helper’. Clinicians will be more susceptible to secondary trauma if they do not have their own unresolved trauma (Blank, 1987). Secondary trauma is also associated more with practitioners who support those with mental health needs (Kuroda and Katon, 2004).

The concept of secondary trauma is used interchangeably with several other terms, such as compassionate fatigue syndrome. McCann and Pearlman (1990) used the term ‘vicarious trauma’; their work focused upon investigating the inner psychological effects upon ‘helpers’ experience of countertransference reactions in response to repeated empathic engagement with traumatised people. Countertransference responses can potentially encourage an over-identification with patients (Herman, 1981) or of meeting their own needs through their work (Corey, 1991). Therefore, countertransference sometimes has less to do with empathy concerning a patient’s trauma (Figley 2002) and more about the therapist’s pre-existing personal characteristics. Their response could have been triggered by some unresolved life events from their own experiences, “A function of his or her previously unresolved psychological conflict” (McCann and Pearlman, 1990, pg. 136). This could be important as the Clinician's emotional world is not separate from the person attending the WDG.

Understanding the expectations of the network around the C/YP in need of help was alive in Miller (2016) paper. Miller talks about how the Clinician may have to coordinate and monitor what is needed and respond to these needs as the network may become helpless and reactive. I could imagine this would put additional pressure on the CAMHS Crisis Clinicians. Miller (2016) helpfully considers the unconscious pressure and thinks that it may be underestimated, as is the impact on the personal and emotional strains inherent in such a task as managing a Crisis. The Clinician may have to deal with the worried relatives and professionals, for whom the behaviour of the

C/YP may have generated distressing feelings of impotence and resulted in thwarted attempts to control the C/YP. Relatives may expect the Clinician to produce the results that they have failed to achieve and even complain when clinicians cannot get quick solutions. Consequently, the Clinician is under pressure from the patient and their network, who seeks relief from the disturbance, especially during a crisis. When feeling under attack and pressure, a defensive system can become integrated into an organisation's culture, and I would assume this could also be the case in the CAMH crisis team.

Social defences in an organisation

It is generally accepted that working on the front line of health services stimulates anxiety and uncertainty amongst staff members (Ballatt & Campling, 2013). The Literature review discusses how a job that is emotionally challenging can frequently trigger feelings of guilt, blame, dependency and vulnerability (Obholzer, 1994, cited in Marks, 1995). The concept of social defences was originally developed by Jaques (1953, cited in Whittaker, 2011, p. 482) to refer to 'unconscious collusions or agreements within organisations to distort or deny those aspects of experience that give rise to unwanted emotion'. Awareness of these defences will be helpful to keep in mind as the WDG progresses. In the classic paper, Menzies Lyth (1959) speaks about this in particular, revealing how anxiety around working with vulnerable and sick patients led to the creation of social defences by nurses, which became institutionally embedded. Hinshelwood and Skogstad (2000) outline how organisations are shaped by anxiety and maladaptive social defences that, if left unexamined, can have a detrimental effect on clinical practice (Hinshelwood, 1989; Jaques, 1953; Menzies Lyth, 1959).

Menzies-Lyth (1988) described the focus of deep anxiety and distress within the job situation'. She writes:

> "Associated with this, there is despair about being able to improve matters. The defensive system collusively set up against these feelings consists, first, in fragmentation of the core problem so that it no longer exists in an integrated and recognizable form consciously and openly among those concerned. Secondly,

> the fragments are projected on to bits of the ambience of the job situation, which are then consciously and honestly, but mistakenly, experienced as the problem about which something needs to be done, usually by someone else. Responsibility has also been fragmented and projected often into unknown others, 'Them', the authorities" (Menzies-Lyth 1988, p. 287).

Learning and conclusions

The learning gained from the literature review identifies and illustrates the complexities of the task at hand. The inclusion of the psychoanalytic paradigm was beneficial for understanding dynamic processes linked to this research. It is clear from the literature that a WDG is not a one fits all approach but aspires to be related deeply to the working environment of the professionals attending it, which can add to its uniqueness. The participants generally do not have any specialist psychoanalytical training. A common theme from the authors is that a WDG could be viewed as an evolving endeavour that involves the participant considering unconscious aspects of human communication linked to the emotional experience of the work context. A comment theme in all the papers is that a WDG typically involves the professional discussing their work within a group of peers with a group leader developing and aiming to support a space for thinking where insight is encouraged.

My literature review also showed a limited volume of thinking about presenting WDGs in CAMHS. Similarly, aspects of my report will bring attention to an important area that hasn't been written about previously. No papers were directly based on presenting a WDG within a CAMHS crisis team, which added uniqueness to this research study. This suggests that the report that follows on my intended topic will be breaking new ground. Further, I found no research papers that considered the facilitator's experience setting up and facilitating a WDG within a CAMHS crisis team.

The literature that I found regularly mentions the complexities of the task of running a WDG. Almost all authors understand this to be a sophisticated task. Authors frequently made it clear that a WDG needs to be bespoke, and there is no one-size-

fits-all approach that will be successful. A common theme from the authors is that a WDG can helpfully be viewed as an evolving endeavour that involves participants considering unconscious aspects of communication.

CHAPTER 3: RESEARCH DESIGN AND METHOD

This study explores my experience of setting up and facilitating a Work Discussion Group (WDG). I carried out this research as part of my studies in working towards the Doctorate in Child and Adolescent Psychoanalytic Psychotherapy. My professional background includes several years as a Senior Social Worker in a community CAMHS Team. In the past, I attended several WDGs. I found these WDGs interesting and wanted to learn more about these experiences. Therefore, I took the year-long specialist psychoanalytic training group workshop during my second year of clinical training. The research I carried out was not within my own direct work setting, which is in a community CAMHS based in the outpatient department of a hospital. Instead, the research was based on my experience of setting up and facilitating a WDG for a CAMHS specialist Crisis Team over six months, with each weekly session lasting 75 minutes.

This chapter begins with the rationale and the research philosophical assumptions for choosing the research methodology to analyse and understand my experience of setting up and facilitating a WDG. Then, the research design and analytical strategy are outlined in two parts, 1) data collection method and 2) data analysis method. My' field notes of my own experience are used for the data analysis. In the second part of this chapter, data analysis, the process of choosing Reflective Thematic Analysis (Braun & Clarke 2018), is explained along with a description and a demonstration of how it was used in my study. Finally, Etherington's (2004) ideas about reflexivity in research are also thought about.

> "Reflexivity is an ability to notice our responses to the world around us, other people, and events, and to use that knowledge to inform our actions, communications and understandings. To be reflexive, we need to be aware of our personal responses and to be able to make choices about how to use them. We also need to be aware of the personal, social and cultural contexts in which we and others live and work and to understand how this impacts on the ways we interpret our world". (Etherington, 2004, p. 19)

A research design that describes interprets, and explores my experiences was needed. This was best conducted using a qualitative approach, which relies on words and narratives as to quantitative research with its focus on numerical data. Strauss said, “Qualitative research allows researchers to get at the inner experiences of participants, to determine how meanings are formed, and to discover rather than test variables” (2017, p. 13).

My philosophical assumptions as a researcher

Denzin and Lincoln (2000, p. 76) suggest “that questions of method are secondary to the question of paradigm”. The research Paradigm is defined as the belief system that guides the investigator. It influences the choices of method and considers the ontologically and epistemological factors that determine the events to be noticed in fundamental ways.’ My Ontological position for this study was a social constructivist research perspective. My Epistemology Position being Interpretivism**.** Etherington (2004, p. 71) suggests that “An understanding of what it means to know (epistemology) and ones view of reality or the nature of being or what is (ontology) are intertwined in qualitative research”. The Interpretivist approach suggests that facts are based on perception rather than objective truth. Gray (2014, p. 193) emphasised that

> ‘”The underlying idea of the interpretivist approach is that the researcher is part of the research, interprets data and as such can never be entirely objective and removed from the research. Interpretivists are interested in specific, contextualised environments and acknowledge that reality and knowledge are not objective but influenced by people within that environment. This philosophical outlook is more subjective and open to biases, thus cannot be generalised in the way that positivist research can be”.

Data collection

In order to answer the question, I needed to extract data from my Field Notes and analyse the data in a meaningful way. Therefore, an important consideration was how much data should be analysed and how to go about it. Furthermore, I needed to gain and present an authentic experience from the data, which meant I had to consider my defences. Defences could close down uncomfortable aspects of the experience; by using a psychoanalytic lens, my defences were considered. Hollway and Jefferson advocate the use of psychoanalytic concepts, such as countertransference, Klein's theory of splitting (1946) and Bion's theory of containment (1962b). In doing this, I became a 'product of the relationship' (Holloway and Jefferson, 2000, p. 41). As "we cannot be detached but must examine our subjective involvement because it will shape how we interpret the data" (Hollway and Jeffers 2000, p. 30).

Psychoanalytic theory was the supporting theory used because the guiding principle of psychoanalytic work is the free association of the mind to allow exploration without conscious censorship. This is a complex area, and self-awareness was important but still had its limitations. The data was collected from my field notes, and without these field notes, the observations on their own would have little value. There was a distinct way in which I recorded the field notes to ensure accuracy, consistency, and worthwhileness. The best way I could ensure this was to write the field notes immediately after each WDG. As the primary data source, the field notes needed to be carefully thought about and have a format that fitted with the research question. The field notes were the core of the data collection; I needed a tried and tested framework. I let the data settle in my mind and trusted my own experience of the data to see what would come out of my thoughts. I will discuss the method I used in greater detail in the stages of Reflective Thematic Analysis (RTA).

Field notes

The proforma for my field notes were adapted from the work of Josina Vink of the CTF Service Research Centre (Karlstad University, Sweden) and the work of Chiseri-Strater and Sunstein (1997).

It was essential to include as much information as possible in my field notes. Chiseri-Strater and Sunstein (2013) have developed a list of practical things that could be incorporated in the field notes:

1. Date, time, and place of observation
2. Specific facts, numbers, details of what happens at the site
3. Sensory impressions: sights, sounds.
4. Personal responses to the fact of recording field notes
5. Specific words, phrases, summaries of, and insider language
6. Questions about people or behaviours at the site for future investigation
7. Page numbers to help keep observations in order

In addition, there are four major parts of field notes that should be kept distinct from one another in some way when writing them. The four parts include:

1. Jottings
2. Description of everything that can be remembered.
3. Analysis
4. Reflection

The field note template (Table 3) I used had five columns adapted from the work of Vink (1997).

Column 1: In practical terms is like a process recording of the words that were spoken during the session. It was impossible to record every word in exact detail. On occasion, I had between four and six people in the room where many words were exchanged. I made an informed subjective choice of what to include in the field notes. I aimed to be open to the essence of what was happening during the sessions. However, this could be open to criticism and scrutiny.

Column 2: This column focused on my emotional experience of the atmosphere within the session.

Column 3: This was my immediate experience of coming out of the session and what was most alive in my thoughts.

Column 4: A reflective stance on my own learning about what could help progress the work.

Column 5: Facilitator's summary reflections after completing the first four columns.

Within the field notes, there were no 100% clear demarcation lines in what was recorded. Instead, these were taken as meaningful, focused prompts to think widely rather than rigid criteria that would exclude observations.

Table 3. Proforma used to record field notes

1)What happened. Summary of the experience. Memorable spoken words or phrases.	**2) My emotional experience as a facilitator that day.** What were my personal and countertransference responses?	**3) Detailed reflections** Why do I think things happened this way? What did I notice afterwards?	**4) Learning** What could I learn? What could I do the next time? What did I do during the seminar that was useful or hindering? (Evaluation)	**5. Summary reflections.** Based on a brief review of the first four columns.

Selective sampling

I decided to use a purposeful sampling method to pick the sessions I wanted to analyse in much greater detail. “The purposive sampling method is about selecting samples from the overall sample size based on the researcher’s judgment” (Sharma, 2017, p. 751). In planning to tell the story of my experiences of setting up and facilitating the WDG, I quickly realised that I needed to think about what made this story come together in a meaningful way. I did not just want a long narrative of my story. Also, as a researcher and facilitator, I needed to be careful not to lose significant aspects of my experience.

I had an extensive data set in my field notes. These Field notes consisted of approximately 36,000 words that are closely linked to my experience. I reviewed the field notes and started to think about significant shifts in my learning and how I could start to add meaning to these experiences. Patton (2002) suggests, as discussed in Suri (2011. p65), that the logic and power of purposeful sampling lies in selecting rich data to study in more depth. Information-rich data are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry; thus, the term purposeful sampling.

This sampling strategy’s potential shortcomings were unconscious; I may have chosen aspects of the work that seemed to focus on positive elements. Thus, maybe not reflect on the messier painful elements of the research study. Instead, I tried to counterbalance my own biases and defences by using my research and clinical supervision to become more aware of areas of the research that warranted more attention and required more reflection.

As Suzuki et al. (2007) noted, “the pond you fish in determines the fish you catch” (p. 295), underscoring the importance of the selected aspects of purposeful sampling in data collection as opposed to convenience or random sampling.
I examined the different approaches to sampling data as I had a large selection of data to think about and manage. Initially, I planned to use selective sampling with very set inclusion and exclusion criteria. Patino & Ferreira (2020) suggest that it is helpful if investigators not only define the appropriate inclusion and exclusion criteria when designing a study but also evaluate how those decisions will impact the external validity of the results. I struggled with having very set criteria before exploring and

getting to know the data; I was unsure of what would be significant and rich and did not want set-in-stone criteria before I started to reflect more on the data. The purpose sampling approach developed by Patton, known as Opportunistic or Emergent Sampling, appeared more helpful. 'Opportunistic, emergent sampling takes advantage of whatever unfolds as it unfolds' by utilising 'the option of adding to a sample to take advantage of unforeseen opportunities after fieldwork has begun' (Patton, 2002, p. 240). I will focus on the opportunistic approach, which allows much more freedom and is more congruent with the reflective aspect of the Thematic Analysis.

In conclusion, firstly, I prioritised sessions that seemed to illustrate something meaningful about the research question and encapsulated essential events within the life cycle of the WDG. Secondly, this exploration will involve looking for data that recognises emotional transformation linked to using the "psychoanalytic paradigm" (Bradley 2008, p. 77) as an aid to help add meaning to my research study.

Clinical Supervision

As my research study will be working within an environment that involves thinking about real-life clinical material, it was important that I would have a space to bring the clinical aspects of the WDG to think about what may be happening.

It was agreed that the clinical supervision of the research study would be provided within the Tavistock Child Psychotherapy training programme in a weekly Small Group Clinical Supervision (SGCS). I attended this group with four other clinical trainees, and the seminar leader was a Consultant Child Psychotherapist based at the Tavistock with extensive experience in facilitating WDGs.

The role of clinical supervision was discussed in my research progress meeting with my course and research tutor, and it was agreed at this meeting that Clinical supervision would be important to monitor boundaries, achieve clinical depth, and support me in thinking about what may be taking place at a clinical level within my research study. Bradley suggests that clinical supervision is

“ A joint endeavour of this kind can, and does, enable patterns to emerge within the patient and between patient and therapist and leads to ‘insight’ of a most memorable kind” (1997, p. 56)

The structure of the SGCS is that you must bring a detailed write-up of your session. The student’s write-up can focus on any area of their work, such as individual, group, or organisational dynamics and is written in the style of a process recording. The author of the write-up reads to the group with the feedback focusing on unconscious processes within the interaction. I had the experience of how helpful an SGCS can be as I attended an SGCS during the first two years of my clinical training. The SGCS focuses on the psychoanalytic paradigm considering the inner nature of things, aiming to bring a more accurate perception of self and others through consistent feedback and containment, supporting emotional and intellectual understanding of what is being experienced within the material. The SGCS space is provided weekly based on a rota of each student presenting their write-ups of the particular area of clinical practice the student wants to think about in the SGCS. After the student presents their clinical material, initial feedback is given by the Consultant Child Psychotherapist, with peers to follow.

I now want to briefly demonstrate the benefits of the clinical supervision I received during the research study. As already mentioned, this was within the SGCS. The focus of the material that I brought was on the lack of spoken words from the Clinicians attending the WDG. At this time, I was worried about what appeared to be the lack of engagement by the Clinicians. The write-up I presented was in the early months of the research project. During this example, I presented my write-up based on what appeared to be limited sharing from the Clinicians within the WDG. At this time, there were long periods of silence in the WDG. This experience resulted in me being left without knowing what was happening in the Clinician’s minds. I had temporary feelings of confusion, helplessness, and frustration. The SGCS helped me think about how the Clinicians were testing me to see how I would deal with not knowing what would happen next. This test was to see if I could manage and experience what it was like to be left with similar feelings that Clinicians experience during their risk assessments with the C/YP. During these risk assessments, there are so many uncontrollable factors that the Clinicians must try to manage, which leaves the Clinicians feeling frustrated. The Clinicians at this stage had started to briefly talk about

the C/YP resistance to agree to risk management plans as one of their jobs' main difficulties. In a way, what was being mirrored within the WDG was similar to what the Clinicians experienced daily. My Clinical Supervisor's comment in the SGCS:

"It sounds like the Clinicians want you to experience what it is like to be left with uncertainty and more importantly what you do with this uncertainty ".

As I settled into the clinical supervision, it helped develop my clinical insight and supported my reflective capacity as a practitioner-researcher. For example, during the turbulent set-up weeks of the group, I found it challenging to establish myself as a facilitator rather than an 'expert' supervisor or manager. It was important to notice the implicit calls of the group for me to shift my role. A peer in my SGCS found a way to put this into words for us to think about:

"You cannot be responsible for the Clinician's ideas of who you are or, more importantly, may represent in their minds."

My Clinical Supervisor s comment in the SGCS helped develop my confidence and shape my practice:

"It sounds like the team is valuing the WDG more than in the previous session; maybe now, on occasions, you will have to take their feelings of resistance up more with some of them in order for them to get an experience of the robust framework you appear to have established".

In general, the SGCS helped me reflect on my experience and better understand the resistance within the WDG.

Data Analysis

I explored several different approaches and considered Interpretive Phenomenology Analysis (Smith, 1996); this method places experience at the heart of the data by investigating how we understand our lived experiences. However, I wanted a broader scope, which offered more freedom. I wanted to learn as much about my own experience as possible. Although I was the subject of the research, I wanted to present and gain as authentic an experience as possible from the data. Being so intricately

linked to the data, I wanted a level of distance between myself and the data. This involved me focusing on observable or semantic content and then scrutinising what lies beneath (Boyatzis, 1998) by exploring the deeper latent meaning with the focus on answering the research question.

The method needed to be flexible and reflective to fit theoretically with how the data was collected; these requirements led me to Reflective Thematic Analysis (RTA), which considers the phenomenological understanding of how people make sense of the world and their individual experiences. Thematic Analysis is "essentially independent of theory and epistemology; it can be applied across various theoretical and epistemological approaches" (Braun and Clarke, 2006, p.5). There is no perfect kind of data for Reflective Thematic Analysis (RTA). With this in mind and the ability to respond and understand my data deeper, I decided to look into the reflective nature of Thematic Analysis (TA). This reflective approach to T A has developed to focus on the ability to be able to reflect on the data as it creates new meaning and not be restricted to a set of themes that one may feel obligated to focus on if they were developed at a stage in the work that has not got to the essence of the experience. RTA allows this flexibility and freedom. There are six main phases in carrying out Reflexive Thematic Analysis (Braun & Clarke 2019).

Although these phases are sequential, and each builds on the previous, analysis is typically a recursive process, with movement back and forth between different phases. These were not rules to follow rigidly but rather a series of conceptual and practice-oriented tools that guided my analysis to facilitate a thorough process of data interrogation and engagement. The analytic process can blur some of these phases together. More inductive, semantic and (critical) realist approaches tend to cluster together, ditto more deductive, latent and constructionist ones. In reality, the separation is not always that rigid. What could be important was that my analysis was theoretically coherent and consistent. A thematic analysis at the latent level goes beyond the semantic content of the data, and starts to identify or examine the underlying ideas, assumptions, and conceptualisations – and ideologies - that are theorised as shaping or informing the semantic content of the data. The latent approach seeks to identify the features that gave my experience that particular form and meaning.

Braun and Clarke (2019) in considering the RTA approach, advised that you need to think about which approach suits your project and actively decide on the 'version' of RTA you chose to use. Generally, within this RTA, you do not conceptualise themes as 'emerging' from data, and the idea that they do is problematic (e.g. Braun & Clarke, 2006, 2013). This language suggests that meaning is self-evident and somehow 'within' the data waiting to be revealed and that the researcher is a neutral conduit for the revelation of said meaning. In contrast, in RTA the researcher conceptualise the analysis of the data as a situated and interactive process, reflecting both the data, the positionality of the researcher, and the context of the research itself. The position around this is not unique or particularly radical. Researchers within a qualitative paradigm tend to treat research as a subjective process. Braun and Clarke (2019), speak about being an active co-productions on the part of the researcher, the data/participants and context.

Now I will demonstrate how I analyse the data using Reflexive thematic analysis based on the six-phase analytical process. Braun and Clarke (2014, 2018) have proposed a six-phase process, which can facilitate the analysis and help the researcher identify and attend to the important aspects of a thematic analysis. In this sense, Braun and Clarke (2012) have identified the six-phase process as an approach to doing RTA, as well as learning how to do RTA. While the six phases are organised in a logical sequential order, the researcher should be cognisant that the analysis is not a linear process of moving forward through the phases. Rather, the analysis is recursive and iterative, requiring the researcher to move back and forth through the phases as necessary (Braun and Clarke 2020). RTA is a time consuming process that evolves as the researcher navigates the different phases. This can lead to new interpretations of the data, which may in turn require further iterations of earlier phases. As such, it is important to appreciate the six-phase process as a set of guidelines, rather than rules that should be applied in a flexible manner to fit the data and the research questions) (Braun and Clarke 2013).

1. Familiarisation with the data: This phase involves reading and rereading the data to become 'immersed' (Braun and Clarke 2018) and intimately familiar with its content. This in itself was like diving into the deep blue sea of words and experiences. I felt overwhelmed by the amount of data in front of me and pulled in lots of different directions; finally, after reflecting on the data, I began to see differences in the data

and noticed events that I had not seen before. By using a funnelling perspective, it was almost as if I was looking down on the data. This familiarisation with the data initially involved adding one additional Column alongside my original field notes. This was alongside my original field notes to make comments of my immediate thoughts on rereading each line; this was helpful as I went over every line several times and wanted a space to add my thoughts directly linked to what I had just read. I started to build up more interesting data in this Column that had a more reflective feel. All the data was still very raw at this stage. I wanted to take all the information from the additional columns and to be able to reflect on all the notes I had put in the additional Column. I put all the new data on several A8 sheets of paper (See appendix I). This process partly helped me select what significant sessions I wanted to analyse and code. This process had started much earlier with my research supervisor. He had helped me explore which method would best fit the research question. We agreed that a predominantly 'deductive (Braun and Clarke 2018) approach' based on self-selection of critical moments of setting up and facilitating the WDG pointed me towards the four sessions to code. By familiarising myself with the data, I noticed some significant developments within the WDG field notes. This choice to focus on four significant sessions was reinforced by reflecting on my research and clinical supervision notes. I started reflecting more on the four sessions; however, at this stage, they lacked depth and rigour, and I was aware my defences could close down uncomfortable aspects of my experience. I used several large A8 sheets to capture my thoughts on the overall experience of these sessions (See appendix I). I went over all the field notes several times again from these sessions. Throughout the data analysis, there was a non-linear process of constantly moving back and forth between the entire data set and rereading the data from the four sessions to continually develop and refine the analysis. This approach helped me distance myself from the data and allowed me to study replication; this provided rigour to meet generalise research standards.

2. Coding: This phase involved generating succinct labels (codes!) that identify critical features of the data that might be relevant to answering my research question. I was not coding my entire field notes and had self-selected four significant sessions to code line by line. The sessions I coded, had a crucial message to tell me about the research question. (Appendix F, G, H, I)

The coding process focused on the four main sessions below

Session 1) The Enquiry meeting is session one, where the WDG idea was presented and discussed with staff from the CAMH Crisis Service Team meeting.

Session 2) The second session to be coded was the first session of the WDG. This session aimed to set the scene and be a blueprint for the rest of the sessions.

Session 3) The third session to be coded was the 18th session out of the 26 Work Discussion Group sessions that were offered. The group was starting to move into a more in-depth stage of work, and the WDG had a more established feeling by now.

Session 4) The last session was where people reflected on their journey within the WDG.

I had over 250 codes from four sessions. In the codes, I tried to look for the story in each section of the data in the field notes. This was done on a line-to-line basis. (See Appendix G)

3. Generating Initial Themes: This phase involves examining the codes and collated data to identify significant broader patterns of meaning (potential themes). It then involves collating data relevant to each nominated theme, so that I could work with the data and review the viability of each aspirating theme. In this part of the work, I started to think about themes and came up with lots of potential themes, but these themes, although helpful, were not real themes in the true spirit of RTA; they were more based on emotional categories, such as Hostility, Curiosity and Anxiety as to themes that got into the essence of the experience. They lacked a meaningful narrative as stand-alone words and phrases; they were potent but lacked substance or coherency in answering the research question. In reviewing these categories and related codes, I needed to look at the codes that could add more integrity to my experience and start to move towards developing themes that capture the essence and give a deeper meaning to my experience. Towards the end of this phase, I had nineteen themes. In thematic analysis, Braun Clarke (2006) highlights how themes do not reside in the data but in

the mind of the researcher “from our thinking about the data and creating links as we understand them”. (Braun and Clarke, 2006, p.7)

4. Reviewing themes: This phase involved examining the nominated themes against the dataset to determine that they told a convincing story of the data and one that answers the research question. In RTA approach, themes are defined as a shared meaning underpinned by a central concept or idea. I was continuously involved in an ongoing review process of thinking about the themes in new ways and looked at them again as I reviewed the patterns of shared meaning. The process involved returning to the A8 sheets of paper again and studying the 19 themes. I looked for themes that had something of a repetitive nature to them. I needed to explore the narrative within the research to add the most authentic meaning to my experience. I grouped the themes and felt that some themes could almost sit on the wall between different themes. I started to think about what brief collections of words could best sum up all the essence of my experiences related to the data. I had to maintain a detached reflective position but yet tuned into the emotional nuances of the data. Self-reflexivity was important, and I needed to be as open as possible to reflect on my own processes. I had thoughts about similarities and differences, how I looked at the data through my own world experience, and my assumptions and unconscious and conscious prejudices.

5. Defining and naming themes: This phase involves developing a detailed analysis of each theme, working out the scope and focus of each one by determining the ‘story’ of my data. It also involves deciding on a name for each theme. By the end, I had four solid themes and 11 subthemes. I tried to remove myself again from the 15 named items and looked at the data again to think whether my own bias may have caused me to overlook something. Three categorical experiences identified very early on (Hostility, Anxiety, and Curiosity) remained persistent in my work. These felt like the foundational pillars of my analysis. Before finalising my analysis, I found it meaningful to add a fourth major theme (Finding middle ground), which emerged later on in both the life of the group itself and my analysis of it.

6. Writing up: This final phase involved weaving together the analytic narrative and data extracts and contextualising the analysis. I had a strong sense of the narrative

of the analysis. I thought about structuring the findings in several different ways. Firstly, I thought about going through each of the four sessions and writing separate sections on each of the themes in each session. However, I felt this could be too confusing for the reader. My research tutor supported me to think about how I could use a simpler but more direct way to demonstrate the themes. This involved looking more at theme development and how the use of words used in each theme needed to be carefully reflected on and represented. A more integrated finding section was the result. For example, anxiety in session one could have a very different meaning in session three.

I was aware as with every method, there is disadvantages and Thematic Analysis as a method is no different. 'A simple thematic analysis is disadvantaged compared to other methods, as it does not allow the researcher to make claims about language use' (Braun & Clarke, 2006. Pp 69). While thematic analysis is flexible, this flexibility can lead to inconsistency and a lack of coherence when developing themes derived from the research data (Holloway & Todres, 2003).

Experiences of self-reflexivity in qualitative research

"I confess I am biased" Burne (2017. pp, 1)

'Self-reflexivity was important in qualitative research because research can be subjective, especially as a practitioner-researcher (Long 2008 pp 131). Therefore, my self-reflexivity was important as the main subject of the research is my experience. Consequently, I needed to be transparent about the process and my role in understanding the data. My inherent bias came about as I utilised self-reflexivity as a continuing conversation about what I included in my field notes and why.

In epistemology, reflexivity implies a circular relationship between cause and effect, especially as embedded in human belief structures. A reflexive relationship is bidirectional, with both the cause and the effect affecting one another in a relationship in which neither can be assigned as causes or effects.

Ideally, qualitative researchers need to be self-reflexive all the time. To date, there have been four specific times that self-reflexivity has been particularly relevant to my research.

- The first was in choosing the area to study. Initially, I wanted to focus more on the Clinician's experiences of attending the WDG. However, because of the limited number of Clinicians available to participate in the WDG and with the help of the review progress panel meeting, it was recommended to focus more on my experiences of setting up and facilitating the group. At this stage, I needed to acknowledge my own biases. This was to avoid openly considering my own experience, as I felt vulnerable about carrying out research on my own experience. However, I had a better focus for my study and a more ethical and robust research question.
- The second time was in transcribing the data. Again, I could see that what I had considered not relevant information was, in fact, adding to a more balanced picture of my experience—this required more rigorous exploration.
- The third time is now as I am writing up my thesis. Like all researchers, I have to wrestle with what to include in the thesis and what to leave out but still offer a strong and unbiased argument. However, I also considered how much of myself to include in my writing. I needed to make this research my own, but not be so strong that the story is all about me but not so weak that a sense of the study is not a true reflection of my experience.
- Finally, to offer practical examples of self-reflexivity, I added personalised comments as a first-line in analysing my data. Actually, choosing these was also a self-reflexive exercise.

There are many ways to be self-reflexive, but no simple guidelines for doing so. Therefore, I have tried to be as self-reflexive and unbiased as possible in the research. When writing up my research findings, I need to be confident and competent. I also need to be honest about what did or did not succeed because such confessions can add a sense of pragmatism. On a more practical note, keeping a research diary, and transcribing the data, have all been helpful. However, I must not get stuck in circular reflexivity of self-reflexivity. I did not want to end up with a thesis containing a series

of self-centred statements. Instead, I will reflexively (and continually) seek to deepen my understanding of my own basis and how they are represented within my writing.

> ‘Reflexivity is the practice of ‘bend[ing] back upon oneself’ (Smith 2012, pp20), where ‘the mind observes and examines its own experiences and emotions, intelligent self-awareness, [and] introspection’ (Sherry 2013, pp283).

Ethical considerations

The ethical consideration involved two main strands; the first one was the functioning of the WDG and how it was organised and facilitated within a robust clinical framework. Thus, adhering to all clinical governance structures within the trust and that I had appropriate clinical supervision in place. It can be emotionally demanding for the Clinicians working with children and their caregivers during a mental health crisis. Part of a WDG is to reflect on practice issues. It would not be unexpected to experience intense emotions within a WDG. It can invoke strong emotional responses, especially within a WDG. This was considered ethically, and I provided each Clinician with details of support services for the Trust staff. Also, a detailed copy of the participant information sheet and to sign and understand the consent form (See appendix C &D). Furthermore, safeguarding is often associated with children at risk of completing suicide. The Clinicians dealt with these concerns and issues in the usual professional way by following best practice guidelines.

Clinicians who gave their consent were advised that it would be fine if they wished to withdraw from the study. A second possibility was also thought about in that any Clinician in the WDG could still attend the group. However, in the end, their data input would not be explicitly included in the study. In addition, it was highlighted that the main focus of the research would be on my experience of the WDG. The ethical framework for the research also included respect for personal autonomy and freedom of choice. In the research, I will aspire to maintain a respectful atmosphere within the WDG. Informed consent was a transparent process based on good governance to maintain confidentiality. The data collected in the project will be held securely for five years after the research study has ended. Integrity, being reliable and open, was also kept in mind. Ensuring there is no conflict of interest and that protocols are made available

Setting and Participants

The physical setting for the research was the CAMHS Crisis Team's own premises. This mainly was around utilising time with a lack of flexibility in the Crisis Team's working calendars. I also thought about how a room in a more neutral environment could have been more boundary and away from the usual setting of the team. However, I did manage to secure a room away from the normal working environment within easy walking distance. The sample of participants was limited as the team members are limited to 4 Clinicians within the shift. I work in the same Trust, but I am based in a different work setting and location. Within a professional capacity, I have never worked or am not involved with the Crisis Service.

The Crisis Service offers crisis mental health interventions and assessments within a National Health Service Health Trust. A crisis assessment is offered if a C/YP is actively suicidal; most requests come from accident and emergency department staff or out of hours General practitioner services.

The process of recruitment and obtaining management consent initially involved arranging a meeting with the Service Manager. Following this meeting and with the management agreement, I emailed all team members who work on two different shift patterns. Next, I organised an Enquiry Meeting immediately after the monthly team business meeting. I invited the Management and Clinicians, presented the study at the meeting, answered questions, and asked for volunteers interested in attending the Work Discussion Group. I highlighted that I hope to use the WDG as a research project. In total, 5 Clinicians were interested in attending the WDG, one on the later shift work pattern and all four from the earlier shift pattern. Some of the staff members worked part-time, and logistic issues made it impractical for them to attend the WDG on a regular Thursday morning; the other two members did not comment at this stage.

Inclusion and exclusion criteria of potential participants

All staff members from the Child & Adolescent Mental Health Service Crisis Assessment Team were invited to attend the Enquiry meeting about the WDG. Each member of the team was either a senior practitioner in social work or a clinical nurse specialist and had been professionally qualified for at least five years. I explained that I would keep anonymous field notes of my own experience of setting up and facilitating the WDG. The aim is to improve the knowledge around the facilitator's experiences. The voluntary nature was explained, and how if Clinicians attended, it would be important, they stayed for the 75mins of the entire session if possible. I explained in more detail that the study purposely focused on my own experience. Therefore, I wished to extract concise data based on my own experience of the study. Transparency was important (so participants knew I was doing the research, alongside being their WDG leader). Clinicians were told that they could take advantage of the WDG, whether or not they contributed to the research if requested, I would remove any notes I had made about their input into the WDG. Each person was provided with a participant information sheet and consent form (Appendix C).

Ethical approval

The Tavistock & Portman NHS Foundation Trust, Research Ethics Committee (TREC) granted ethical approval. (See Appendix B). Ethical approval for the study was sought locally from the Research and Development Team within Belfast Health and Social Care Trust. The Research and Development team deemed the Study Service Evaluation, and the Trust approved the study to progress.

The pre-submission checklist for The National Health Service Ethics via their integrated research qualification system (IRAS) deemed the study project evaluation.

CHAPTER 4: RESULTS

This chapter will illustrate the process of my in-depth coding of my research field notes, which highlighted four themes and eleven sub-themes. These themes will tell the story of significant moments of setting up and facilitating the WDG. To analyse my field notes, I used Reflective Thematic Analysis Braun and Clark (2020) to generate a deeper level of understanding. One of the advantages of (our reflexive version of) TA is that it is theoretically flexible.

> "In Reflective Thematic Analysis, the coding process is unstructured and organic, with the potential for the codes to evolve "To capture the researcher's deeping understanding of the data. Coding is recognised as a deeply inherent subjective process that requires a reflective researcher-who strives to reflect on their assumptions". (Braun and Clark 2021, p. 39)

The findings are derived from the research question, and I made a personal and informed decision about what data to use based on significant stages in the development of the WDG. First, I had a vast amount of field notes to choose from and needed to reflect on all my data to look for pivotal sessions. Next, I needed to generate a clearer understanding of the data through my interpretations. To do this, I needed to study my field notes and move beyond the words to look for deeper meaning with the research question alive in my mind, I was looking specifically to capture the essence of my experience.

> "We encourage researchers using reflexive TA to dwell with uncertainty and recognise that meaning is generated through interpretation of, not excavated from, data, and therefore judgements about 'how many' data items, and when to stop data collection, are inescapably situated and subjective, and cannot be determined (wholly) in advance of analysis". Braun & Clarke (2021, p. 201)

As Patton (2002) suggested, selective emergent sampling helped me think about these pivotal sessions and drew my attention to the following factors. These points assisted me in selecting and analysing four sessions out of 26 sessions.

- The clinicians have concerns and don't think the WDG would be relevant and helpful.
- The clinicians discussed their transference experience to the material they brought to the WDG.
- The clinicians discussed during the week with each other how the WDG session was helpful when working with patients.
- The clinicians are coming on time and have material prepared to present in the WDG**.**

The analysis focused on the themes within the overall setting up and facilitation of the WDG. Ongoing analysis was intertwined and built within the field notes framework. I provide an overview of each theme over the life span of the WDG in Table 4 below.

Please note the following abbreviations within the field notes and results

The following material includes short excerpts from my field notes to illustrate the points to be considered. The excerpts include the Facilitator's Reflections as shown by (F's R), comments from the Team Leader by (TL), and the Clinician-participants by (C). I also identified a session by 1-4 in line with the four sessions I carried out the analysis on (S) and line numbers by (L) in my own data set.

Table 4. Themes in grid format

The four main themes and the eleven sub-themes in the grid diagram give an overview of the developmental stages of the WDG. Each marked box shows that particular themes and sub-themes were more alive within the WDG at each stage.

	Enquiry meeting	**Week 1**	**Week 18**	**Week 25**
Theme A: Hostility and rivalry (a lukewarm handshake from the team)	*	*	*	
Sub-theme A1. Friend or foe	*	*		
Sub-theme A2. We in the team are the experts	*	*		
Theme B: Anxious about intimacy	*	*	*	
Sub-theme B1. Anxiousness, bringing the private into the public	*	*	*	*
Sub-theme B2. Limitations in the task			*	*
Sub-theme B3. Discomfort and progress		*	*	*
Theme C: Curiosity to explore a new landscape				
Sub-theme C1. Curiosity about the WDG		*	*	*
Sub-theme C2. Refreshing thoughts			*	*
Sub-theme C3. Facilitator offering a handrail		*	*	*
Theme D: Finding the middle ground		*		
Sub-theme D1. Making connections			*	*
Sub-theme D2. Shared experiences		*	*	*
Sub-theme D3. Stability within the WDG			*	*

THEME A: Hostility and rivalry (a lukewarm handshake from the team)

At the enquiry meeting, I realised how quickly the room became filled up with words from the clinicians and the management team, mainly about my rationale in requesting the meeting. It was difficult for me to discuss what possibilities a WDG could offer the Team because of questions and remarks and no space to reflect on the questions within the meeting. However, I referred to the context in which a WDG could be helpful. I had a sense from the questions that there was a perception of seeing me as a demanding figure. Not as someone who could add something that may be of value. One significant comment made by the Team Leader (TL) was that the team 'we are very busy'. (S1. L 2) stuck in my mind.

I had a sense of needing to dispel any significant concerns about me being a 'critical judgmental figure' (S1. L 2.). My focus was to discuss my research and seek consent to conduct the research study. Although, I felt my words had little space in the room today as three clinicians' 'looked at their mobile phones and responded to emails' (S1. L 16) during most of the early part of the meeting. I tried to offset any significant resistance by using a gentle tone of voice and listening.

The theme of Hostility and Rivalry could not be considered totally separate from the Crisis Team culture. It refers to important elements in establishing the WDG within the setting. First, a sense of busyness being the norm within the Team. The significance of what busyness means in the team culture. There was a sense of myself either adding or taking away from the busyness. A sense of seeing the 'WDG as a 'non-necessity (F's R. S 1. L 19.), myself as just a temporary visitor within the environment.

> Team Leader (TL). "*The team meeting ran over; we are very busy with lots of new referrals to talk about; it's a real luxury to get time to talk about the job*". S 1 L 2.

Also, where do the Clinicians emotionally locate a WDG, as this is new ground for them as they are maybe not sure what I am offering as no Clinicians have attended one before. Furthermore, why explore a new ground if you are comfortable where you live already. The Crisis Service Managers may see it as important, but do the Clinicians (C) I am offering the WDG 'see it as an instruction to attend as to an

opportunity' (S 1. L 11). Therefore, am I asking them to accept an uncomfortable position that they were not consulted on. The theme of hostility is a sense of general irritation within the enquiry meeting and was linked to the rivalrous feelings around the ownership of time that I will discuss later. This theme encapsulates the struggle to seek permission during the meeting to free up space and time for the Clinicians to think outside the Team's usual way of operating. The sense of Clinicians at the Enquiry meeting not coming on time also highlighted a possible sense of defiance—the Team Leader (TL) comments on coming into the room with four other colleagues.

TL: "You better start, as I am unsure if more people will join, and some people might have to leave early". S1. L 5.

There was a sense at the enquiry meeting, after giving a brief introduction on WDGs, that I was being tested to see how I would fit in with the status quo. For example, Clinician 1 comments, 'That sounds a bit like our group supervision, only you give us directions' (S1 . L 26). At this stage, I wondered if I was seen as the physical representation of the WDG. I was offering a WDG, and for a brief period of time in the meeting, it felt like I was the actual WDG in the Clinicians' minds Clinician 4 Comments.

C4. *"I need to think about the time commitment and whether it will be possible to come and see you on top of other demands*". S 1. L 11.

In studying the material in-depth, I noticed that the rivalry was also linked to the ownership of time; thus, why should the Clinicians give me their time to come to the WDG. 'Like, will you be repeating things we do in the team anyway?' (S 1. L32) At the enquiry meeting, the Clinicians were unsure of what the WDG is, could it be psychotherapy, and what am I offering. The rivalry in the spending of time; time could be seen as a measurement of importance. Rivalry capturing the ownership and use of time around whose time it is and what it should be used for is commonly featured in the field notes related to several codes. The Theme of rivalry encapsulates aspects of undermining what the WDG may have to offer and about the fit of the WDG model to the work of a CAMHS crisis team. In my field notes, I recorded feeling on unstable ground with no foundations.

C3. "*No offence intended, but how do we know this WDG will be of any benefit".* S 1. L 24.

C1. "*I am a bit confused about what this group will be about. I get the bit about talking about psychoanalytic concepts, but will it help me in my day-to-day work. Like, I know you find this approach helpful, but you offer psychotherapy we do not".* S 1. L 49.

There was a sense of my internal feeling of rivalry and feeling 'under pressure' (F's R. L 41. S 2), providing a simple rationale for having a WDG. Several codes related to an experience from the clinicians of ambivalence about the WDG. The idea from some clinicians that they did not want to experience painful emotions was joked away.

C 1*. "We are not dancing clowns who have magic dust to take the sadness away"*. S 3. L 31.

The sense that I had highlighted was that the WDG was about providing a broader arena to consider emotional experiences. This arena was more extensive than certain professionals were used to and stirred up possible hostility. The idea of a WDG being curious about complex and possible emotional distressing topics brought up feelings of wanting to move away as quickly as possible:

C5: *"My job is done, case closed, you can overcook it"* S 3. L32.

My experience analysing the field notes was that hostility became stronger by merely listening to some Clinicians with a sense that I was being attacked just for being there and available. With this in mind, at this time, I wondered was I experienced as an intrusive patriarchal figure who wanted to question a well-defended script from individual Clinicians.

C 5*: "Not too sure if there is much point in me being here in this WDG".* S 2. L 14.

I also tried to understand how difficult the Clinician's jobs were to do and the pressure they were under at times. Furthermore, I understood that what I was asking them to think about could appear complicated and undesirable.

C5*: "I do the assessment and move on to the next one; it's the only way the system will work (C5 laughs and giggles). Long-term work is not my thing, and it is not what I signed for when I joined this Team".* S 2. L 34.

A concern about how much emotional availability would be required to attend the WDG with a perception that the WDG is maybe associated with long-term work with patients. A sense of hostility is linked to these rivalrous feelings; by C 1 letting me know that a reflective practice group in the past had been helpful and could I compete with this experience.

C 1. "*A couple of years ago, I found the reflective practice group I attended useful. That is the main reason I am here today, on top of what you said at the first meeting. Do you give out handouts about the psychoanalytic theory, or should we take notes?"* S 2. L4.

As a facilitator, I felt competitive 'Competition within myself. Sense of pressure' (S I . L 4) within myself was I up to doing a good job. The WDG was not automatically accepted by the CAMHS Crisis Service; there was no red carpet. The essence of this theme in the early phase was about what type of person am I as the visible representation of the WDG. A sense that how I came across was extremely important and would impact the uptake for the WDG.

C3. "*You come across as if you know what you are talking about".* S 2. L7.

Sub-theme A1. Friend or foe

This sub-theme was partly constructed around possible feelings of cautiousness and some apprehension from the Clinicians about my agenda. In a way, I had invited myself to provide the WDG; the Clinicians had not signed up to attend a course or requested the WDG. "Just wondering why you want to do this with a Crisis Team in CAMHS". (S1. L 18)

Facilitator (F). *"The WDG will aim to be a supportive space, and that the main thing to bring with you will be your experience, and a write-up of this experience would be helpful. Such as a process recording".* S 1. L 57.

Additionally, I had a sense of a busy team that had experienced a high level of demand for their service. During the Enquiry meeting, the Clinicians may have experienced me as asking them to do something that requires a level of personal investment and intensity and could be viewed as draining as to liberating on top of an already arduous job. With a sense of no room to escape with no breathing space, 'the atmosphere during the Enquiry meeting felt inflexible' (F's-R. S 1. L 46). The clinicians did not see me as a professional adversary, more of an 'authority figure' (S 1. L 23) who had not earned their respect and permission. At this stage, the question remained was I a friend or foe.

The analysis of my field notes suggested resistance from different Clinicians at the Enquiry meeting. There was a sense of hostility towards engaging in the discussion openly. Which highlighted an experience of the Clinicians seeing me as a foe and also being vulnerable to feeling judged by their peers

> *C 3. "I am a bit worried, as the WDG could feel a bit intensive because everyone is thinking about what you have done or maybe not done the right way with the patient. Do you give us a mark*?" S 1. L 35.

Sub-theme A2. We in the team are the experts

The study would suggest that Clinicians needed to hold onto their expertise, C1 comments 'In my experience' (S 2. L 19) was a word used several times by Clinicians during the Enquiry meeting. The notion of a session focusing on an individual's Clinical material within the WDG was not reassuring for the Clinicians. Additionally, this usually required giving and receiving feedback which was not a welcomed prospect. C2: 'I am worried because that could feel a bit intensive' (S1. L15). A sense of me being a demanding figure in the room that wanted the Clinicians to bring their dirty washing and show it in public was of concern to some Clinicians. My thoughts of the possible liberating experience that participating in a WDG may offer felt crucial to me. I was able to start to encourage the Team to be curious. "I can talk to my Team, so I wonder how this would be different" (S1. L24). In the WDG, C2 expressed anxious thoughts around the Facilitator holding the agenda.

C2. *“Does that mean that you pick a topic that the person has to focus on it, and each person in the group has to talk around this topic concerning their work”?* S 1. L 13.

F. *“The topics or themes we discuss evolve primarily out of the material presented in the WDG. Each person’s agreement is voluntary, and nobody would be told to attend or pressured into talking. Sometimes silence can be important”.* S 1. L 14.

The link between control and anxiety was present within the analysis of my field notes. It was possibly about who was expert enough to own the agenda. The services Clinical Director (CD) being clear that he knows what the Crisis Team needs, and it’s up to me to serve this purpose. I felt anxious, and hopeful but unsure of the (CD) expectations for the Team.

This Theme also captures the sense of being in a space with a group of professional CAMHS staff who had no experience attending a WDG. In my experience, I had a sense of the supportive nature of WDGs. I did not want to do a tough sell during the meeting, as this may have come across as pushy and demanding. If this happened, it may have increased the resistance to thinking together about what a WDG could offer. This mismatch of my experience of WDGs compared to the rest of the people at the meeting felt like an ‘invisible wall’ (F’s -R. S 1. L 23) that I was unsure of the best way to manage at this early stage. I felt challenged at moments as the Clinical Director suggested the Clinicians should be doing training in the WDG, which pointed towards the group’s ownership.

CD. “*The team need something like this…… I have been asking for a long time about support for this team. They have a very demanding job, and your training group will be very much needed”.* S 1. L 39.

At the enquiry meeting, the word ‘training’ did not fit in with the ethos of a WDG. My understanding was that I had to think quickly about my own emotional experiences when being spoken to by the CD and highlight the experiential learning nature of the WDG. The analysis of my processes concerning this showed that I was aware of listening and thinking about the emotional atmosphere within the meeting without

becoming directive and authoritarian. It was almost as if the CD's questions were more statements or attacks as to him just asking me questions at this stage.

> CD. "*Has anyone done this type of research work before, or are we the guinea pigs?"* S1. L 22.

My account of the information from this sub-theme encapsulates a possible attempt by C2 in the description below to disable thinking within the enquiry meeting. However, I also felt that anxiety is part of a natural process around something new.

> C2. "*It would be nice if we all agree. No need for a debating society. That just leads to conflict in the team. Just that word "discussion" causes me to switch off as there is not much room to make mistakes in our job, no point discussing it if the child is dead."*
> S 1. L 60.

If the tension in the team got ignited, the WDG might add a flame. The clinicians may have a lot invested in keeping the status quo within the team. Discussing individual experiences may not be welcome. This space was dangerous and was not that attractive as the WDG may be associated with conflict.

The analysis of my field notes showed I valued the WDG as having something new to bring to the Crisis Team and having my own feelings of anxiousness about being accepted by the Team.

THEME B: Anxious about intimacy

I did not see myself as separate from the research question, linked to the epistemology nature of the study. In the Enquiry meeting, I used words like 'our WDG' as early as possible to promote the ethos of the WDG. However, paradoxically, I acknowledge that I was coming from 'outside the Team' (F's-R. S 1. L. 19). I also felt hopeful during periods of the meeting. The questions from the professionals also brought a certain amount of deliberation and curiosity into the meeting.

> *C 1. "How does it work? Is it like you giving us topics to discuss? Is there a structure to it? Is every group the same?".* S 1. L 11.
>
> *C 5. "I don't feel I need more training to do my job".* S I. L 8.

My own past experience in WDG's highlighted the need to promote collaboration as an important way to promote the experience of what a WDG has to offer. I was not there to do to them but to try and be with them. I comment that it is my job too.

> *F. "It will be my job to set the perimeters around the WDG and work in partnership with the people who want to attend respectfully and sensitively".* S 1. L 59

My experience speaking about the WDG at this enquiry meeting included periods of feeling judged and quizzed by the CAMHS crisis team. During the Enquiry meeting, there was a sense of 'restlessness' (S.1 L. 68) within the room. For example, being asked the same type of question several times. It became apparent that maybe the Clinicians were worried about who had control in the WDG.

> C3. "*Does that mean that you pick a topic we discuss?"* S1. L 13.
>
> C2. "*Do we have homework to do each week, do you give us marks out of 10*?". S 1. L 56.

Sub-theme B1. Anxiousness, bringing the private into the public

The nature of intimacy was alive in this sub-theme. At times intimacy was an uneasy experience for the Clinicians in the WDG that needed to be defended against as it brought up 'vulnerabilities' (F's-R. S 3. L 23). Although intimacy can be a private and personal experience in a way, the WDG did consider feelings concerning work. The 'external and internal world's (F's-R. S 3. L 47.) Mostly around how these world's coexist and could be thought-about within the Clinician's work. Within the material, there was a sense of what type of facilitator/person am I in most of the Clinician's minds. A sense that I was positively viewed as time moved on.

> *C3 "you came across as knowing what you are talking about"*. S 2. L7

In the group, a sense of a fear of intimacy around doing things differently. This excerpt gave an account of Clinicians being cautious, which also needed to be respected.

> C2. *"I just tend to keep my thoughts to myself".* S 3. L 6

C3. *"Working in the crisis service can be hard to switch off from; you just need to learn ways to cope, like alcohol helps (laughter from C3)."* S 2. L 7.

C4*. "I have always done my risk assessments the same way; there is not much I can do if the patient will not or can't tell me if they are suicidal.*" S 2. L 53.

There was maybe a concern regards can 'intimacy be thought about' (F's-R. S 2. L 19) within the WDG. There was a need to separate things at times. Will the WDG be a link between the public and private self, was alive in the sessions

As C 3 comments about the nature of how they carry out risk assessments, I had a sense of a 'fear of change' (F's-R. S 1. L 43). For example, suppose the paper task, based on yes-no answers (risk assessments), no longer serve their purpose. Is intimacy a helpful experience, or is it problematic depending on how each Clinician carries out their crisis assessment.

A sense in the material that the individual nature of presenting a process recording of your clinical work in front of colleagues is anxiety-provoking and can be an intimate experience. Thus, bringing in one's own experience and thoughts from the private to the public was a concern in the WDG.

Sub-theme B2. Limitations in the task

The analysis of this material related to a deeper awareness around limitations of what the Clinicians could achieve within their work setting. A sense of trying to offer a service within a system that is periodically in crisis with lots of shortfalls. The limitations that some patients and families have in moving beyond their difficulties. The theme of limitations was seen as an increased awareness in supporting families to take smaller manageable steps.

C1. "Actually, this thinking together has helped me gain a different perspective, especially around my limitations and what is possible for families and how, at the time, expecting too much can be setting them up for failure". S 3. L 25.

C4. "There is a limit to what we can do for people". S 3. L19.

C3. "I know when to pull back now". S 3. L21.

The WDG is a place to try and be hopeful and authentic about one's limitations and possibilities.

> C2. "*At the very start of the assessment, I now say roughly how much time we have for the assessment".* S 3. L 17.

Sub-theme B3. Discomfort and progress

The study found that Clinicians felt confused at times while attending the WDG. However, there was an acknowledgement of gains and losses. A suggestion that some new thoughts had been planted and developed during the WDG.

> C2. Things that made no sense in the earlier sessions make more sense now. S3. L13.

As a facilitator, I felt I was 'intimately linked' (F's-R. S 4. L 24) to the work of the Clinicians who attended the WDG.

> C2. *"You could think about stuff in here that you would never mention in the weekly team meeting. I felt you understood us, which helped us connect and trust each other, and it was a supportive atmosphere".* S 4. L5.

As the above extract shows, I had a sense of personal satisfaction that I had made a meaningful connection with the clinicians who attended. Many accounts showed that different Clinicians were getting various things out of the WDG. Also, C5 had talked about not needing to attend the WDG without giving any major reason, apart from saying that she had lots of experience of psychodynamic work.

I did not push an agenda to prove the worth of the WDG. Even know in the early phases, it was uncomfortable as I wanted to prove the possible worth of the WDG. I wanted experiential learning to be at the core for the potential long-term benefits of the Clinicians.

> C3. "*I found it helpful but a bit confusing at times, especially as I am unsure if humans have an unconscious mind. I am more of a social constructive type of person. I have realised I can be set in my ways. But I did find it relevant at times, and nowadays, I tend to give my feelings more say".* S 4. L 3.

(F's-R) It was worth sticking at getting the WDG off the ground. This WDG does suit some of the team members. S 4. L 4.

C1. *"The WDG has been helpful; I am kind of going to miss it. Over the last couple of months, what we thought about started to fall into place, mainly around needing better boundaries and trusting myself more".* S 4. L 44.

Other accounts related to the Clinicians discomfort about the ending of the WDG, this loss of a place to come away from the normal Team and think about events differently. It was going to be missed by some Clinicians.

C1. "*The WDG time has gone so quickly, and to my surprise, I have found it helpful in many ways, if not a little difficult at times. I didn't feel it was too demanding and the atmosphere was relaxed. I won't forget some of the discussions as they did help me understand my head and not be as quick to judge, especially around just focusing on the parents".* S 4. L 2.

THEME C: Curiosity to explore a new landscape

This theme depicts some Clinicians being more curious about their emotional experiences; in ways, there was a sense developing in session two that the language in the WDG was that of the emotions. There was a sense at times of emotions being unpredictable and disguised.

C4. *"I am interested in what you said about repeating unprocessed painful emotional events from the past* ". S 2. L12.

Clinician's talked about their struggles in their daily work. C2 'I was left just feeling confused' (S 2. L 27) connected to a sense of uncertainty about what is meaningful when trying to support their patients. My curiosity as a facilitator was around trying to communicate an 'authentic understanding' (F's-R. S 3. L 15) that added insightfulness to the experiences.

C4 talked about needing meaningful experiences more than just the spoken word. This Theme was partially around Clinicians developing a curiosity to consider their emotional reactions to direct patient work.

> C4. *"It makes me wonder more about what I take on board, like emotional stuff. To be honest, I can feel drained most days; when I go home, I am just exhausted".* S 2. L 10.

The Theme around a developing sense of curiosity being linked to feeling safe enough to be slightly curious. The Theme, Curiosity is demonstrated when C5 speaks about challenging aspects of her work.

> C 5. *"I will talk briefly about this patient. I am intrigued about this girl and feel this group is possibly where I could talk about her. This girl was a crisis referral from her G.P. She is a 12-year-old girl who had told her father that she would hang herself on her 13th birthday. She had picked a tree to hang herself from and had hidden the rope. She also cut her arm, needing several stitches just the day before".* S 2. L 19.

Clinicians shared about starting to 'think together' (S 3. L 18). This may have suggested a developing experience of having a 'place away' (S3. L 57) from the normal Crisis Team atmosphere to promote curiosity.

> C 4. *"I do not like to think that my job impacts much, but it does in some ways. I tend not to listen to my emotions as that usually results in me being too worried. Maybe that is why I kept moving jobs and was interested in coming along today".* S 3. L 12.

Sub-theme C1. Curiosity about the WDG

The word WDG in the enquiry meeting represented the clock face. Some accounts suggested that the Clinicians needed to know what goes on behind the clock face. Clinicians wondered where to place it; one Clinician's question 'is it like a staff therapy group' (L 36. S1). There was a sense of needing a map or signpost to think and give the term WDG a landscape and provide a reference point for the clinicians to help them add meaning to this new term.

F*: "It can be therapeutic. However, it is not a psychotherapy group for staff; it focuses on awareness rather than exploring personal issues in any great depth".* S 1. L 37.

A sense that the questions were a helpful place for thinking. The questions were relevant and discussed in a thoughtful, careful way. I commented that during a WDG.

F: *"People try and listen and aim to give helpful feedback*". S 1. L 55.

My experience was around the Clinicians wondering if there is a place to be curious in this WDG or is it simply more of the same. A sense of willingness and interest from the Team who asked questions about the WDG approach; this demonstrated a level of being ready within the enquiry meeting to be curious together. The curiosity was around the possibility of moving into a new novel working space. Inquisitiveness was alive in the sessions, C3 comments, and "Think I will give it a go*"* (S1. L 65). The sub-theme captures a willingness to attend the WDG.

(Clinical Director): "*What happens, what actually happens in the group, on that day"*? S 1. L 54.

This account communicated that my role in part was to offer reassurance to the Clinicians and answer questions. I held onto the hope of the prospect of a WDG within the CAMHS crisis service. A sense that some of the professionals were looking for something slightly different, maybe something dynamic, exciting, stimulating and refreshing but safe. I needed to stimulate this sense of curiosity, so I focused on the active and reflective learning aspects.

F. "*Gain new insights into your experience of being with a patient with the main focus on experiential learning"* S 1. L 27.

C . "*That is good; I do not have to sit and write more reports about my patients and bring them to another meeting or group of professionals. Most days, I spend long enough on a computer".* S1. L 30.

F*. "Each WDG is different and is shaped by the individuals attending, but there may be some common topics. These topics can come out of us thinking about communication on two levels, the conscious being one part and the unconscious being the second part of the mind. We consider what is happening in the work*

as we discuss it together. At times I may integrate some psychoanalytic concepts to the discussion". S 1. L16.

The Clinicians wanted more active involvement in the learning process than just sitting in one place and staying in one position. I was trying to convey a sense of freedom away from being judged on marks and outcomes. I commented that one of the aims is for an opportunity to expand your learning experience in a respectful environment.

F. *"I certainly will not be putting you under any pressure to attend".* S1. L 50.

Sub-theme C2. Refreshing thoughts

Some accounts suggested that the Clinicians felt that the WDG helped them 'trust themselves more' (F's-R. S 4. L 12) by increasing their reflective capacity. Clinicians talked about more self-belief in their own experiences 'I am a bit more direct about how I see things' (S3 . L40). In addition, the codes highlighted the Clinicians appreciating their clinical work being discussed.

C 3. "*For me, there was something about getting away from the regular team meeting, just a different atmosphere. It helped that you came from the outside; you had no history. I discussed things that I would never mention in the weekly team meeting and found some of the feedback helpful".* S 4. L 5.

This drew attention from the Clinicians to understanding human nature and how it related to their job. As the Facilitator, I felt that gradually, I did not have to work so hard for the Clinicians to become involved. The Clinicians wanted to think about their work and were open to my interpretations and peer feedback. In addition, I experienced more insightful comments from the Clinicians as the codes indicated. In general, the Clinicians did not appear so defensive about their work and were more open to different thoughts.

C2. *"All I can say is that I will not think quite the same way about my work that I used to before coming to the WDG. It just made sense about my feelings towards certain situations in my work. Other parts, to be honest, I disagreed with, especially the discussion we had about defences around the C3 case. I think that could be just an excuse for people being rude".* S 4. L 9.

Moreover, this encapsulated a shift in outlook by C2 & 1, as resulting in them being more able to understand aspects of their own emotional experiences and to question and 'disagree' (S 3. L 34) with me.

By attending the WDG, there was a chance to understand better the challenging concept of projections in a practical way. Some excerpts gave an example of this, 'something nasty came into my head, like a projection I think' (S 4. L 34). Consequently, the Clinicians have more of a sense of not being pulled into the same level of acting out behaviour, 'If my mood changes quickly, I try and reassess my emotions.' (S 4. L 39) The Clinicians are aware of repeating behaviours.

> C3. "*It helped me not fall into the same trap of pleasing the parents and losing the child's focus".* S 4. L 41.

There was a sense in the codes that it was refreshing to discuss work with peers in the WDG and introduce some psychoanalytic interpretations. In addition, the idea that the Clinicians 'I am taking something new away' (S. 4. L 47) having learnt something new helped demonstrate the value of the WDG.

There was a sense that old ideas being partly let go off to accommodate some refreshing thoughts. For example, C3 suggested that the WDG 'Helped me not feel as stuck' (S 4 . L 40), a sense of openness to let go.

> C3 "*The WDG helped me think about my work in such a way I have been more able to switch off when I come of shift".* S 4. L 5.

These new thoughts or experiences gained in the WDG were helping the Clinicians make different assessment outcome recommendations. For example, C2 'I tend to keep my assessment recommendations simpler now' (S 4. L 52)

There was a sense that the group had helped clinicians 'My head is just clearer' (S 4. L 24) was a comment from one Clinician. In addition, there was a sense of more self-awareness.

> C3 *"I am just more aware now of what is not spoken about, and I felt sad thinking about this girl"* (S4 . L31).

There was a sense that there was a new awareness around holding the child patient more in mind. For example, C2 stated being more able to withstand the demands and challenges of parents who may have lots of needs.

C2. "*Something uncomfortable about forgetting about the young people as their parents tend to take over the assessment room. Now I know in some ways why I felt frustrated".*

(F's-R) C2 is starting to trust her thoughts. S 3. L 37

C3. "*Now we are thinking about it; it just shocks me how quickly it can happen and how easy it is to forget about these young people and focus on their parents".*

(F's-R) The neglected child can be thought about in the WDG. S 3. L 40.

Thus, I gently challenged and supported the Clinicians to trust and reflect on their reactions to their material they presented in the WDG. A sense in the codes that I had brought a few new challenging ideas into the Clinicians work.

C2. "*It was practical and helpful in the way you brought in some different things. But I would need to do more training alongside the WDG to get more out of it. I will need a break to reflect on my learning and maybe get a couple of books you mentioned".* S 4. L 52.

This may suggest Clinicians being able to stay more with the anxious feelings and not trying to push them away or act out of them.

C2: "*Usually, I would have panicked, but I just give her more time".* S 3. L 24.

C 3. "*It felt like no one wanted this girl. It is not very professional to say this, but I had a feeling of anger towards this child's mother. I wasn't sure if it was all my emotions or hers. It did get me wondering more about that transference experience".* S 3. L 16.

An idea of the Clinicians dealing with unwanted aspects of people's lives and the WDG being a place that accepted these undesirable aspects that may have been repressed in the past. This may suggest the Clinicians as being more curious about the psychoanalytic understanding of their patients and their own emotional experiences with their patients.

C1. *"I never thought that the Psychoanalytic ideas were so relevant to my practice. What we talk about in the WDG stays in my head, and I think about it during the week. In the past, I would not have been that comfortable thinking about how rejected this child may have felt".* S 3. L 19.

Sub-Theme C3. Facilitator offering a handrail

A sense that I had to use every opportunity I had to support the Clinicians to engage and be curious in the WDG. I listened and observed; by this, I meant being present as I listened without closing it down or intellectualising it; this in itself proved extremely important. I was trying to make meaningful connections—my own past experience of WDG's being very alive in my mind. I wanted to support the Clinicians to feel safe and wanted within the WDG. I needed to connect to parts of the Clinicians minds that enjoyed and valued being seen and listened to as a holding experience. A Clinician talked about finding the first meeting interesting I felt this was important and asked for his thoughts.

> F*." I wonder what it was I said that sparked your interest".* S 2. L 9.
>
> C1. *'I like the idea of having you here once a week over the next six months'*. S1. L 34

This sub-theme included a sense that a supportive environment would promote a sense of curiosity in the WDG, which encapsulated my wanting to acknowledge and decrease anxiety by offering a sensitive helping handrail. Furthermore, encouraging an understanding of some of the possibilities that a WDG could offer.

> F: "*Hopefully, the WDG will be an experiential learning experience and build on previous learning".* S2. L 5.
>
> C 4: "*To be honest, I am not sure why I am here. I liked what you said at the earlier meeting about the mind's different parts shaping behaviour".* S 2. L 8.
>
> F: "*Thanks for sharing your thoughts, that's important, but some confusion is usual and welcomed".* S 2. L 15.
>
> F. *There is not any right or wrong way, just what you experience.*
>
> (F's-R) Trusting oneself. Building belief. Redefining practice. S 2. L 46.

By analysing my field notes from the early sessions, I felt uneasy about whether this group could come together and function as a WDG, and I used examples from my experience, which I had found helpful when attending a WDG several years ago.

> F. *"My immediate reaction was to give up on working with this child as it felt like she had rejected my support. Still, through the WDG, I continued working with*

this adolescent girl and was able to explore her fear of males, and I was guided by the support of the WDG". S 2. L 42.

THEME D: Finding the middle ground

The analysis relating to this theme felt that a line had been crossed based on the Clinicians engaging more meaningfully in the WDG. The analysis of my field notes highlighted several things, starting with me no longer needing to remind the Clinicians about the next WDG session. Over the last several sessions, the Clinicians generally were prepared and in the room on time for the WDG session to start. The rhythm of the WDG sessions had been established and mostly protected within the Clinician's working week. The Clinicians were taking ownership of the timetable of who would be presenting their clinical material in advance of each session. This Clinician's sentences started with it is my turn to present in the next WDG session as in the earlier sessions; I would have been asking about what Clinician's turn it is to present in the next session.

C 3: *It's my turn to present next, and I would like to talk about a 14-year-old girl I was asked to assess last weekend. I thought it would be interesting to hear other people's thoughts in the group.*

(F's-R) The Facilitator was thinking about the ingredients of the daily work. Curious about why C 3 wants to talk about this patient. A sense of more trust in the WDG. S 3. L 5.

Furthermore, a sense of the Clinicians allowing themselves to talk without the same concern of being evaluated by their peers. The following session demonstrated a level of openness.

C 1: "*Total brass neck, it just gets worse; I feel angry around these parents, I think I have started to understand what wavelength some of them operate on, and I do not get pulled into justifying my position; it is pointless now. It just used to take up so much time, and they have no ownership around helping their children. I just need to stand back and remain professional".*

(F's-R) The seminar group is a place to bring unpleasant thoughts. My role as a person that can gather the group and creating a space to think. S 3 . L 23.

In the discussion within the group, the Clinicians started to relate and link in session material from earlier WDG sessions. The data analysis revealed a sense of commitment with the Clinicians being on time for the WDG and notifying a peer or me if they could not attend. The middle ground suggested a place that characterised an emotional 'investment' (F's-R. S 3. L 42). There was a sense of connecting more with their feelings in the work. For example, 'I felt sorry for this child' (S3. L 23). The middle ground was a place of shared ownership of the WDG; words like 'our' (S 3. L 25) had started to appear more often. The essence was that Clinicians were more actively engaged each week in the WDG. Thus, building on the previous sessions led to the Theme of "Finding the Middle Ground". The middle ground was a space to think about the past and how to prepare for the future. The clinical material presented was from past clinical work. At times, the discussion involved integrating psychoanalytic concepts that I initially brought into the session and was reflected on by the Clinicians.

C2*:" But I am finding out that each week when I talked, I usually come away not feeling so confused, especially around projections and transference and how these may impact my thinking".* S 3. L 8

C2: "It's reassuring each week to know I have this space to think about my work". S 3. L 29

Words thought about now in the WDG now included transference, projections, unconscious and conscious mind. These words were no longer total strangers in the WDG. C1: mentioned 'it's like they projected this confusion into me' (S 3. L 23)and how she was more aware of these experiences. There was a sense that these concepts partly symbolised what was on offer within the WDG. There was a sense that the middle ground was a more reflective place. 'I kind of reflected' (S 3. L 24). Notably, it was a place to think about the best way to help the patients with more of a focus within a boundary relationship. I needed to be careful as the Facilitator and 'not bring all of my thoughts' (F's-R. S 3. L 42) into the WDG, which would have impacted the shared learning experiential ethos of a WDG. I encouraged the Clinicians to integrate their thoughts and experiences with knowledge gained from previous sessions. A sense that the middle ground was a bridge built between the public and

private place, which could withstand bringing the future worries and past experiences into the present during the WDG session.

F. *"I am just wondering what you experienced in that moment?"* S 3. L20

Sub-theme D1. Making connections

This sub-theme encapsulated a sense of the Clinicians integrating the learning from the WDG into their jobs. The Clinician's clinical material being presented in the WDG demonstrated more awareness of deeper thought processes. This awareness did not switch off at the end of the WDG session. The findings show evidence of the WDG being more present in the Clinicians' minds during the rest of the working week.

C 3. *"Something about what we all thought about during the last session; in a way, it does not sound possible. In the previous discussion, this popped into my head, and I wondered if there is a paper I could read on psychoanalytic theory. Like how a patient could impact how I feel a certain way, especially this patient as she did not say much".* S 3. L 8.

The Clinicians were moving beyond feeling pessimistic at times about having uncomfortable feelings—that I did not have to encourage the Clinicians to discuss their work. At times a sense of a different type of freedom in the WDG about the Clinicians being more confident in their own emotional experience as there is a stronger belief that logic doesn't always apply during a crisis assessment.

The WDG was becoming more of an emotional workshop for the Clinicians to experiment with thoughts and wonderings and make connections. A sense that the work can be painful at times. Thus, patients can impact how you feel and that you're not a neutral observer carrying out assessments. Therefore, a greater sense that the work is a complex emotional process. An experience in my Thematic Analysis of the material is that the work is not always about making connections with people that an internal connection can happen in your mind, which can help you better understand what may be going on in the work.

The sense also of the more harmful aspects of the mind. How healthy thoughts can be attacked and sabotaged to maintain unhealthy connections. The demands for

intimacy, even if it is harmful and damaging. Clinicians were feeling safe and more able to take on board thinking about more in-depth material.

> C4*. "At times, things just come into my head from an earlier session, which helps me in the present situation*". S 3. L 12.
>
> C4*. "This mother is so unhelpful, but her daughter still craves her attention; that is an unhealthy connection".* S 3. L 23.

In the analysis, there was a sense of the Clinicians making meaningful links with each other within the WDG by wondering more about communication on an unconscious level from their patients and their families.

> *C2." We have our own mini WDGs when assessing patients, especially in the A&E Departments".* S 3. L 31.

There was a sense in the WDG of ongoing struggles to make sense of experiences that the clinicians had with their patients that were painful and demanding. In addition, the Clinicians had to deal with feelings of rejection, frustration and isolation. The Clinicians were now looking at the WDG to help them make connections and make sense of these complex interventions with their patients and the systems around them.

Sub-theme D2. Shared experiences

This sub-theme is linked in part to the Clinicians starting to share their emotional responses. The experience of having a place in your mind helped the Clinicians develop a different perspective on situations with a sense that in some small but meaningful ways, the WDG at times was a place to still the mind in a thinking way.

> C2. " *In the group, you can put the brakes on and share an experience".* S 3. L 19
>
> C4*. 'Now that I am saying this, I too feel like that sometimes, just lost for words'* S 3. L 23.

This experience link to sharing an emotional experience and slowing thoughts down to a digestible speed with an awareness that the Clinician's own emotional experiences can be thought about and shared in the WDG. C 3 presents their clinical material by talking about challenging areas of practice.

C 3: "*Yes, that about sums it up; well, as you would say, that is what I was aware of, not sure what else was going on in my head during this assessment session, but there was something about wanting to escape it felt important, like something I needed to think more about in the group".* S 3. L 23.

F. "*Maybe thinking about what feels uncomfortable may mean you can use these feelings in a helpful way for yourself and your patient".* S 3. L 18

This sub-theme encompassed the Clinician's interest in their own emotional experience. This sense of openness to be curious and make connections was not an abrupt change but, one of a gradual process. I found it extremely important to be curious and alive in the WDG by refreshing my mind and not being afraid to wonder alongside the Clinicians. In addition, there was a new sense of these interpretations being valued and discussed by the Clinicians within the WDG.

C2. "I am learning from my peers' experiences as well, especially around the transference, which I do not totally get just yet". S 3. L 34

C2. "It is helpful to use the psychoanalytic material concerning this patient but to be honest, it's also reassuring that I am not losing my mind, and my peers have had similar experiences". S 4. L 12.

Sub-theme D3. Stability within the WDG

This sub-theme encapsulated an experience of providing a physical space that had an established pattern to each weekly session. At the very start of setting up the WDG, I had to be active by asking questions and encouraging the Clinicians to go into more detail in the group; as the sessions progressed, the balance became more even. The goal was for the WDG to support the Clinicians in gaining new insights based on their own experiences.

C4 *"I liked how the group helps you think without feeling judged".* S 4. L 45.

A sign of this was when the Clinicians started to take ownership of the clinical material they wanted to present in the WDG. As time went on, I did not need to encourage members to bring their write-ups. 'I think it's my time to present next week'. (S 3. L 12) This in itself was important as I was no longer seen as an outside authority but

more of a helpful, professional companion along the road. The WDG was being experienced as a useful space.

> C: 2 "*I find it useful because the WDG has been outside the normal team atmosphere. What I experience in the group, especially when I present my work feels real".* S 4. L 48.

It is also about having a less disjointed view of their patients by bringing different pieces of practice together and getting a better perception of their patients' worlds.

> C3. *Not too sure if I could quickly put it into words, but it certainly has helped me bring some of my experiences together and help me not be so quick to react. I can see patterns now within my reactions and thoughts to some of the families I work with where I would not have in the past.* S 4. L 43.

A sense from the analysis that Clinicians found attending the WDG beneficial. An awareness that the WDG offered an opportunity to reflect and learn away from the normal team business. A sense in the codes was that a helpful connection was made between the C 1 and the WDG; this was not in one specific area but in a general way.

> C1. "*There are lots of views in the Crisis team meeting. I think what I liked about this WDG set-up was that you could breathe and not worry about saying and thinking about negative feelings towards aspects of the work. I realised how difficult it was to do that in my team meetings. This group was more real for me, and I will miss it, but hopefully, I will remember some of the discussions. I want to do more of this type of learning. I was surprisingly shocked as I have never been a big fan of psychoanalytic material before".* S 4. L 7.
>
> (F's-R) A sense that some Clinicians and the Facilitator will miss the WDG and are mourning today. A sense that a meaningful connection has been made. S 4. L 7.
>
> C3. *It is a pity the group has to stop, could you come back in the future. I am curious to learn more. The psychoanalytic material made more sense after a couple of months. It felt like an onion with lots of layers.* S 4. L 11.
>
> C 2: *Could* we *run a new group?* S 4. L 13.

In the last session, it was refreshing that the Clinicians felt the WDG was directly pertinent to their practice and encouraged them to think more reflectively. A different

type of learning experience, in a pragmatic way. They were moving beyond just words when trying to understand their patients' needs.

C1. *Yes, so have I; it has been interesting and helped me understand people and how what they say is not always what they mean. Something a bit different, if not somewhat refreshing.* S 4. L 49.

(F's-R) Not dull, exciting learning together. Having a sense of helping the Clinicians think about the importance of thinking. S 4. L 49.

C2. "*It was practical and helpful the way you brought in some different things that we could think around. I believe it needed a personal connection, like the way you encouraged and supported me helped build my confidence. But I think I would need to do more training to understand better all it has to offer".* S 4. L 23

(F's-R) Feeling a personal connection to the C 2 today. I had a sense of a new hunger in the Clinicians for more WDGs. S 4. L 23

The analysis in the sessions illustrated a place in this CAMHS Crisis Team for this WDG. I had a sense of 'sadness' (S 4. L 34) in the last session. I was leaving the Clinicians who had become important in my mind. My own observations about my writing at this stage were that I noticed I had included a greater volume of the Clinicians' work, and perhaps this illustrated the value of the actual expression of the Clinician's words. It was very poignant to have lived so closely with my notes from all the sessions and the Clinician's words, and there is something about giving them more space in these last pages of the findings. Also, I had a sense of achievement, a sense that it is hard to say goodbye after an initially challenging but meaningful experience. In the next chapter, I will open the lens back up more to think about theory and other professional voices. A sense that time moved quickly, and it may be helpful to offer more WDG experiences for the Clinicians in the future.

CHAPTER 5: DISCUSSION

Within this chapter, I will be reflecting on the main themes through a psychoanalytic lens. I will move on to consider the culture of the Crisis Team and how this was related to the study. In addition, I will be discussing what challenges the WDG faced. Following this, I will discuss what made a WDG in the crisis setting different and how did I notice and respond to this difference. In my self-evaluation of the study, I consider what did I manage to do well? What was challenging? What did I learn that I could build on if asked to do another WDG in a similar setting? What recommendations for practice and future thoughts about research?

As I will refer to "Splitting, Projection and Projective Identification" (Klein 1959), I have decided to briefly overview the theoretical basis of these concepts that underpin the thinking in my discussion chapter.

> "The basis of these concepts comes from the work of (Klein, 1959). She suggests that in the earliest months of life, the infant splits his or her perception of 'mother' (using this term to designate primary caretakers) into good and bad. Positive experiences—feeling fed, warm and calm—are perceived as coming from a good mother whom he or she loves, while negative experiences—feeling hungry, cold or anxious—are perceived as coming from a bad mother whom he or she then hates and wants to destroy. Klein referred to this as the paranoid-schizoid position (P/S); paranoid because bad experience is attributed to others seen not only as depriving but as persecuting because the infant fears reprisal for these projections; and schizoid because the central intrapsychic process involves splitting. She chose the term 'position' rather than 'stage' because we are all prone to returning to this way of interpreting our experience throughout life, when anxiety becomes unmanageable. With maturation, infants become aware that their mother is a single person who sometimes meets their needs and sometimes fails them, and for whom they feel both love and hate. This capacity for ambivalence for recognising that one has both loving and aggressive feelings towards the same person—is an essential developmental step. Klein called this more integrated relating to the world the depressive position (D/P) because it brings with it feelings of concern and remorse for the damage and pain that we

have caused to those we love by our aggressive demands and attacks. From these feelings of guilt comes the drive to reparation—to atone, protect and repay the good care that one has received—which forms the basis of all creative, productive and caring activities we engage in from infancy onwards. However, if guilt is too strong, the anxiety about one's capacity to effect reparation can become overwhelming. In this case, reparative activity will be inhibited, and the infant—or the adult in whom these early conflicts are revived—retreats to the earlier, more primitive mental activity of splitting their perception of others as all-good and all-bad, who can then be ambivalently and separately loved and hated" (Foster, Roberts, 1998, p. 3)

THEME A: Hostility and rivalry (a lukewarm handshake from the team)

The theme of hostility and rivalry was not what I had expected to evolve so strongly from the RTA; I had expected some level of resistance in trying to establish the WDG. However, in preparing to write the discussion, I am reminded of the nature of the unconscious mind and how defences against any feelings of vulnerability can bring up defensive feelings and can be split of into good or bad. My experience was that logical explanations were not adequate in offering the WDG and that the learning had to be experienced to be understood. No matter how well I thought I explained what a WDG could offer, it felt insufficient. Initially, in the analysis, I thought of hostility as a negative issue to overcome. However, I also experienced it as a signpost about what was concerning the clinicians, which on reflection, helped in shaping my practice as a facilitator. I had to think, was I offering reassurance quickly enough, or did I need to stay longer with difficult experiences to create a thinking space.

"Just as the mother has to tolerate a baby's sometimes irksome and disruptive dependence, so those offering therapeutic relationships need to be able to contain their 'hatred' of the other's dependence on them until greater independence is achieved". Winnicott (1947 p. 195)

The Clinicians in this study had no experience of attending a WDG before; in a way, in the early sessions, I was the physical and emotional representation of the WDG and was initially seen mainly as a foe. I had to see the hostility as what it was, which was only one part of my experience. Part of the Clinician's hostility was based on not having requested the WDG or not having signed up for a training course that involved a WDG, as had been more common in some of the articles from the literature review. However, this WDG was a voluntary arrangement with no formal requirements for the clinicians to attend. I had gone seeking them, as they had not requested my input or help, and on an unconscious level, they could have been acting negatively as they may have viewed me as thinking that they could not cope or needed help, and in the transference, hostility may have been invoked to prove to me they were strong and were the experts. The clinicians initially did not engage quickly in the WDG and felt uncontained at times in the WDG.

> Failure to provide such a container leads to a state of 'nameless dread' in the infant. These ideas are useful, for example, in conceptualising the role of the consultant to an organisation as trying to create a setting (container) in which difficult emotions can be safely explored or, as Bion might put it, where thought can emerge and develop. Containment in an organisation is provided by effective management. Foster (1998, p.102)

In general, the split outlook decreased significantly by the time we reached the theme of The Middle Ground, seeing me more as a friend to foe. Bion's(1959) concept of the "work group culture" fitted well with more of a focus within the WDG on having meaningful experiential learning within a secure structure designed to facilitate the attainment of group goals and satisfaction of the WDG members' needs by being in a dynamic space. In a way, it was an invitation to demonstrate a curious state of mind to the team by being present and listening and observing deeply in a non-authoritative way and promoting the practical use of psychoanalytic concepts.

> 'We do not rely on the spoken word, the overt answer to the direct question. The psychoanalytic psychotherapist (or indeed any other acutely observant and thoughtful interviewer) is very aware that so much more needs to be taken into account". (Goldstein et al., 1986, p.33)

THEME B: Anxious about intimacy

Anxious about intimacy was a wide road. During the Thematic analysis, it took me by surprise how interlinked it was to most aspects of the WDG. Everyone has histories of being in many groups, starting with their families, with a mixture of experiences; this needed to be held in mind. This exploration in the clinical material presented in the WDG sessions was very much focused on the clinician-patient relationship. With this in mind, most relationships have an emotional connection or value. The Theme around anxiety about intimacy focused on being willing and able to experience emotional connections with patients, which touched on one's own feelings of vulnerability. I had the experience as a facilitator of the power of emotional communication within the WDG. C5 talked about the WDG not being her type of place as she felt anxious if she had to think as to just doing a risk assessment. I want to take a deeper view of this fear of thinking which Klein called a paranoid/schizoid position, where thinking is hated, and uncertainty cannot be tolerated. Bion states that a healthy mind(1984, p. 67) "requires a capacity to tolerate uncertainty" because its function is to work out what is going on and how to respond to it.

In a way, the WDG experience was about supporting the Clinicians to tolerate a level of uncertainty without becoming defensive and remaining open to their own emotional experience. Of course, anxiety did not disappear, but intimacy within the WDG promoted curiosity which supported the Clinician's to gain new knowledge.

> In a similar context Mendelsohn (2007, p.145) "I have defined intimacy as a cognitive state that relates to knowledge of one's psychic reality. I have also suggested that one's emotional attitude towards this knowledge is the affective component of intimacy. Whereas intimacy is thus an intrapsychic process, it is an interpersonal process as well. One must first be intimate with oneself before one can be intimate with others. Psychoanalysis is a technique in which the major goal is increasing knowledge of one's psychic reality, that is, where the major goal is intimacy".

Anxiety was present, but a different type of anxiety than those related to the themes of hostility and rivalry. The anxiety about intimacy was more related to an unconscious fear of feeling helpless around the limitations of what is achievable within a crisis assessment. Working with a suicidal adolescent is not without its challenges and the boundaries around who has the fantasy of who has the power to choose who lives or dies. For example, will the C/YP attempt to commit suicide again. The notion of a safety plan which may require a request for hospital admission to an adolescent inpatient mental health unit which in today's current health service, is a minimal resource and cannot always be action if a bed is not available. These are uncomfortable thoughts that Clinicians may automatically not want to hold or try and build an intimate connection with the C/YP. Within this complex experience, the C/YP and the parents or network also project their anxieties into the clinicians which causes anxiety about intimacy. However, in the WDG Clinicians talked more freely about having intimate emotional experiences when working with the C/YP.
The WDG has limitations, and boundaries was an important aspect to feel safe enough to promote a sense of intimacy.

THEME C: Curiosity to explore a new landscape

Curiosity was an important experience to capture from my thematic analysis. In the context of this WDG, being curious about your own experience of a situation required a level of courage and the ability to think about new possibilities. The urge to know, called 'K' by Bion (1962a, p.42-43), affects how we behave, relate, think, and see the world. The process of change within the WDG involved forward and backward movement between holding beliefs and being curious about something that is experienced as being different within the Clinician's own experience and how they related to the C/YP or Network. The experience in the WDG aimed to be as authentic and empowering, bringing benefits to the working lives of the clinicians by reworking off situations and challenges. Working through the Clinician's material each time in small ways promoted emotional room for greater curiosity and trust within the WDG. In general, psychoanalytic theory helped think about the conscious and unconscious and how we may not be aware of what is getting in the way in the work as it could be below the threshold of conscious awareness. In other words, the blocks to our good

functions are unconscious. In a way, a growing curiosity was essential to overcome some of these blocks by linking aspects of thinking and experience together in a meaningful way. Psychological achievements within the WDG led to a sense of self and the conscious capacity to think more about their work in relation to unconscious processes. Bion took Freud's ideas about drives to a different level. First, he categorised the drives as emotional links, which he called L and H, standing for love and hate. I take these to represent Freud's schema of life and death instinct. Bion added another concept, K, which I have already mentioned and stands for knowledge and refers to the emotional link of knowing the other. I wanted to relate this to the theme of curiosity as being associated to Bion's K about seeking knowledge. The positive consequence of this is the development of consciousness by gradually building on the discussion and interpretations and adding new meanings within WDGs.

To make room to be curious, emotional space needed to be available; this happened as some of the Clinicians started letting go of yes and no answers; these answers had a level of superficial certainty and comfort built into them. Developing curiosity required me not to fill up every silent moment in the WDG with words for the sake of not thinking in the silence. Within the team, there was a number of Clinicians who shared similar beliefs and values and had a professional identity built around these viewpoints. Another way to describe the difference is that two-dimensional thinking is rewarded by being right and being able to demonstrate that, whereas the three-dimensional process is rewarded by the pleasures of discovery and creativity. The concept of a third position turns out to be crucial for thinking and promoting curiosity, especially for the capacity to think in a crisis setting.

> Since the paranoid-schizoid position involves interpreting one's experience in two-party terms (one good and one bad), bringing in a third party (the 'third position') in itself supports a shift towards a more depressive position functioning. Foster (1998, p.12)

Over the 26 sessions, the place of having refreshing thoughts was not a place of arrival; it was more towards moving to the 'depressive position' (Klein 1956). Overcoming complex defences in groups, as discussed by Menzies Lyth (1960) in her brilliant paper, talks about defences taking the form of informal grouping, held together

by shared ideas that have more impact on the organisation's preoccupation with the formal structures. This was part of the challenge of going into an already established team, as in the early period, I felt the odds were against me. My experience as a facilitator was to cultivate a sense of curiosity by being non-threatening or demanding change, but by believing in Bion's (1962) concept of a healthy interest in having an authentic experience of gaining knowledge.

If anxiety within the WDG had become disabling, curiosity would not have taken place as the WDG would have eventually disintegrated. It was very much about the members of the WDG being flexible enough to consider other experiences as having value and of interest. In a way, I demonstrated a curious state of mind to the team by being emotionally present and listening deeply in a non-authoritative way and promoting the practical use of psychoanalytic concepts.

THEME D: Finding the middle ground

I had to keep an open mind and be ready to take into account each individual's Clinician's views. In a way, develop an appropriate level of intimate connections by being emotionally and attuned as a facilitator. My experience was that the Clinicians needed to feel understood, which was crucial for the survival of the WDG. There was room for understanding different viewpoints in the middle ground as there was an established conceptualisation of space between the Clinicians and myself. This required the acceptance that not everyone attending the WDG sees and thinks the same way. The WDG needed to have room for differences as well as similarities. In a way, by being more separate, we could think in a more meaningful and integrated way. The importance of creating a 3-dimensional community space by offering the safety of an emotional handrail was very much about me as a facilitator, letting go of needing to know but being aware and emotionally available in a good enough way. I did not have all the answers for the Clinicians. I had a doubt in my mind about my own lack of expertise, but aware that I had experiences and knowledge that could be of value to the Clinicians. This flexibility in my approach was attractive and reassuring as I was not setting myself up as having lots of simple answers. At times, the middle

ground was as much about what I did not do as to what I did do; this tuning in required time and space for understanding to develop and have meaning.

> "Several psychoanalytic authors have written about the good enough mother taking time to discover what was distressing her baby. However, they all agree that an authentic sense of empathic connection is a process, not an instant event". (Winnicott, 1953; Pick, 2011 pg. 18).

As the WDG progressed, it started to become more secure and stable. It had established a foundation built on familiarity and containment. The need to bring an ongoing sense of movement and emotional aliveness helped the Clinicians make connections and feel contained within the WDG. The sense of internal and external gentleness was essential to establish the middle ground.

> " It seems to be essential that we develop our capacity to be kind in our work" Stokoe (2020, p. 170)

In order to do this, I had to support the Clinicians to move away from some firmly held beliefs. This required containing their anxiety in a manageable but gentle way; this involved process feelings in the WDG around loss and change. The specific psychoanalytic concept of containment (Bion, 1967) indicate the need for the 'vessel' in the form of the community and worker to be able not only to hold on to the disturbance but also to 'digest 'and process it.

Moving away from the anxious state where thinking is hated is linked to Klein's theory (1959) regards the paranoid-schizoid position (P/S) at one end of the spectrum and the opposite end, the depressive position (D/P). P/S thinking is two-dimensional thinking and depressive position thinking is a three-dimensional place. One of the main structures of the P/S state of mind is the requirement for certainty. Absolute certainty is equated with safety; safety is about staying free from anxiety. I accept that at times I was aware of acting out and needed to pull back from providing a sense of false security to influence the Clinicians. I could see that the provision of certainty in the presence of anxiety would have made me appealing to those otherwise filled with anxiety. However, this was not in the ethos of a WDG,

with a focus on experiential learning. In a way, again, I am discussing so much what I had not to do as also discussing what I had to do to secure the middle ground. The middle ground focused on making meaningful connections built on understanding as best I could the complexities that the Clinicians faced each day in their work.

> I want to make a distinction between understanding and being understood and point out that patient who is not interested in acquiring understanding-that is understanding about himself-may yet have a pressing need to be understood by the analyst. (Stener, 1993, p.321 Cited in Stokes 2020)

This feeling understood promoted emotional movement in the WDG. This was noticeable in the WDG as the Clinicians started to complain more as to holding grievances; a grievance is something hard to let go of and can be narcissistically defended against as it may serve an unconscious purpose. I was challenging a familiar way of working and was struck by how quickly the WDG could become totally absorbed by grievance, focusing on lack of responsibility for considering different perspectives. As Weintrobe (2004) highlighted, the difference between a complaint and a grievance is that in a complaint, one is hoping that this will lead to a resolution and emotional movement. However, it was evident that the middle ground was more mature as grievances decreased.

As the facilitator, I was often reminded of Bion (1962a) writing around letting go of memory and desire at the start of each WDG. This was as much to make space for newness as to also learn from my own experience. I found I had to be willing to learn in order to open the space for connections in the WDG. This shift was gradual as everything in the WDG had to build momentum before any shifts in thinking were possible. The sharing of experiences reminded me of attending a five-day Group Relations Conference which offered me a direct experience of being in a group but without the usual structures that shield participants, to a greater or lesser extent, from the raw emotional experience. It was at this time in my own development that I witness the P/S position within the Group Relations Conference, an experience I will never forget.

> “A group relations conference defines itself as a ‘temporary institution’ (Stokoe, 2020). It limits its own structures to the absolute minimum in order to accomplish its own primary task, that of providing a place in which issues of organisational defences, leadership and authority may be studied in vivo. It is the absence of the ‘ordinary’ structures that create such a unique experience”. (Stokoe, 2010, p.158-159)

What supported growth in the WDG, and what challenges did the WDG face?

I want to write a little more about the influence of the unconscious and conscious processes within the Crisis team culture and how they may have been acted out within the WDG. I am conscious I have already mentioned this several times throughout my dissertation, and it is not directly related to just one central theme. What was clear around the team’s culture was how quickly the Clinical Director (CD) assumed control of the agenda. The CD at the enquiry meeting was vocal about the team needing training, and it was almost as if it was my task to provide this training. At this moment in the enquiry meeting, I wondered what agenda was I fulfilling and thought about the culture and history of the team.

> McCann and Pearlman stated (1990, p. 301) “observed, a request for a facilitator must never be taken at face value, and careful investigation may reveal that what is primarily needed is a review of management and leadership issues on the unit. In fact, a possible danger in such a situation is that the facilitator may unwittingly exacerbate pre-existing leadership conflicts rather than help to resolve them. At the very least, in such situations, the facilitator’s presence may be used to delay or avoid confrontation of the real problem”.

Within the WDG culture, new interpretations were not always welcomed, and I wondered did this mirror out issues within the wider team. The thought of some of the Clinicians within the WDG contemplating a move from a set professional position was at times challenging and difficult to move to a more integrated, less narrow-focused position. In addition, it was challenging for individual Clinicians

within the WDG to go against the unconscious processes within the Crisis Team culture, which was more action based as reflective.

> "A key tenet of psychoanalytic theory is that mental processes that are "hidden" and operate at an "unconscious" level can impact employee behaviour outside of their awareness. Given the value of this knowledge to organisational leaders, it is surprising that so little is known about the potential impact of "below-the-surface" motivation on employee attitude, engagement and performance". (Kets de Vries, 2009, p. 12).

The Clinicians in the WDG were cautious about what may be emotionally required to reflect on change. Feelings of vulnerability were present in the culture and at times needed to be defended against. The WDG asked the Clinicians to think about emotional experiences.

The learning for me was initially around thinking about the culture of the working environment of the Crisis Team. I had the challenge of having to bring the WDG with me in my mind and hold the WDG frame as I tried to establish it within the team. I experienced feelings of helplessness and frustration, but these quickly passed. I wondered about the clash of cultures and the boundaries between the outside and the inside.

> "Boundaries in psychoanalytic work are different and, unless that difference is understood, we can't construct proper enquiries into the work". Stokoe (2021, p.103)

> It was helped by having the same time and structure of each session as an essential part of getting the WDG established. This is bread and butter in the psychoanalytic world; however, this was not easy to establish in a culture of crisis work with a high level of pressure and lack of certainty about each Clinician's working day. My inside experience was reflected in my field notes this linked to holding the space accessible in my mind and not feeling intimidated or rejected in the early sessions by the hostility, for example, clinicians getting the days and times confused, no one volunteering to present or discuss their work, double booking themselves in their diaries.

The material from the RTA linked a rivalrous culture with the ownership of time and how the time should be used within and outside the WDG. Rivalry was also around in the culture about who held the authority as the expert. The sense of the fantasy of who holds authority over the thinking space was linked to seeing and splitting me as either a friend or foe. Importantly for me, the initial clash of cultures was in terms of not being absorbed and fitting in with the culture of the Crisis Team and to bring a more wondering mind-set, which was seeing me as a foe to the everyday culture of not questioning the unconscious processes and working linearly.

What makes a WDG in the crisis setting different? How did I notice and respond to that?

Establishing a WDG in the CAMHS Crisis Team reminded me of offering an opportunity to firefighters as they tried to put constant fires out. These fires were not small fires but potentially life-consuming fires. For me to be ignorant of the pressure that the clinicians were under would have been extremely unhelpful in trying to get the group established develop a rapport with the team. The metaphor I kept in my mind was of the WDG being a small island surrounded by water as forest fires went on to the mainland.

Having been involved in several work discussion groups over the last ten years, through this research, I have come to realise that there is no such thing as a normal WDG. To be ignorant of the participant's external and internal stressors would go against the ethos of a WDG. At times the WDG was in crisis, with projections from the outside were brought in and sparks were flying. However, these projections were some of the best ingredients for learning within the WDG. I was very much the outsider at the start, in a room full of people who had put out many an emotional fire. The reason this WDG survived and prospered was a lot to do with my internal frame of reference and my own mind-set. Going into an established team was a challenge, but also I remembered that I was bringing something new and hopeful, and the very presence of a new person created a new group with new opportunities for learning. Holding hope was important.

Self-evaluation of the study

Getting to grips with the dynamics in the team early on was important; I did this by letting go of the notion of needing to provide watertight answers. The clinicians generally had strong personalities; they were not yes people by nature; they had a level of confidence in their own abilities. This was helpful in lots of ways, mostly around having a sense of their own internal egos, which promoted resilience and the ability to think of the other. I needed to manage this in such a way that I did not appear patronising or self-righteous but yet intellectually and emotionally attractive enough to offer an opportunity that was not simply a matter of asking them to read a chapter in a book but more asking them to trust me enough to commit to attending the group if no one attended the group it would not survive. The group needed to stay authentic to the ethos of WDGs this in itself was a challenge as I felt at times the clinicians just wanted me to agree with them and compliment them on the work they were delivering. The challenge of offering something attractive needed to be balanced with the experience of offering something that had to be experienced in order to be relevant. I learnt that I needed to be aware of my own expectations of myself in a realistic way and allow space for my own learning.

I thought about the power of unconscious processes and was reminded of Freud's famous comment, 'It is a very remarkable thing that the unconscious of one human being can react upon that of another, without passing through the conscious (Freud, 1915 cited by Stokoe p. 32). This question was continually reflected in my mind around what influence my own emotional world was having on the WDG and the data I was collecting. I could not be directly aware of my own unconscious, even after years of analysis. I used several things to help me think through my own unconscious processes. Mainly this was my peer discussion research group, individual research supervision, my field notes and personal analysis. These reflective methods helped me transform some helpful feelings into conscious information about the WDG, especially getting the WDG established. In writing up my field notes, I had to be quite disciplined as I found myself disorientated and tired after facilitating each WDG; at times, I felt excited but exhausted. Sometimes I felt superior other times inferior, these feelings were not stupefying feelings, but they seemed to be a common experience after each WDG until we found the stability of "The Middle Ground" (Theme). I tried to

complete my field notes as quickly as possible, but I found I needed to take a quick Cup of coffee or a brief walk for a couple of minutes. My field notes helped me make sense of my experience and helped me think about my own unconscious processes more. The possibility of what was projected into me at the different stages in the WDG helped develop my field notes, but there also was something about my field notes helping hold together my thoughts and not losing my centre-ground and observational stance. Price and Cooper (2012, p.64) say it is 'almost inevitable that identification with research subjects and their ordinary defensive functioning occurs'. The idea of the transference helped me consider the relevance of countertransference to my research experience.

On a totally personal and professional level, without my psychoanalytic backbone, I would have struggled, and I do not believe the WDG would have progressed the same way. I am not saying that having had a personal analysis, robust training, research, and clinical supervision made me immune to the projections of working with disturbed and painful parts of the human mind, but it did support me to work within a boundary relationship within the ethos of Work Discussion. This paper highlights the need to be emotionally cautious with one's own and other minds.

Implications for future clinical practice

Upon completing the research, I identified several practice issues that I felt would be helpful for my own and others' future clinical practice. The learning that came about was based on ongoing reflection and integration of the outcomes of my research study. This reviewing process was within an informal Action Research paradigm around generating ways of developing clinical practice. Learning from experience is typical of an Action Research (Meyer 2000) approach. Kemmis and McTaggart (2002, p. 595) described it as *participatory research*. The authors state that action research involves a spiral of self-reflective cycles—the four stages of Action Research. I will briefly give a real-life example of these stages in action and how I took the learning forward.

Figure 2. Kemmis and McTaggart ‘work cycle’ of action research

Stage 1. **Plan**: The change process mostly involved offering an induction session for the practitioners interested in attending a new series WDGs. The reason for this induction session was that I had the impression that the provision of the WDGs was so unlike the sorts of spaces that these clinicians had elsewhere and were familiar with in their clinical practice. It seemed too big a stretch for them to find a way for them to use a session fruitfully from the start. I had the idea of offering a specifically identified induction session which would be a chance to bridge between what they were familiar with and aspects of what we may be doing in this particular setting. This was not a teaching seminar like other groups they may have participated in during their careers. The idea of the induction session was to provide a space for an informal conversation about the possibilities of what a WDG would offer.

Stage 2. **Take action**: I was asked to offer a WDG to a generic community CAMHS team. I included an induction session with the main focus on the practical applications of the ethos of a WDG to real-life professional experiences. The focus of the induction session was on bringing more attention to the experiential ethos of WDGs. I planned

to encourage the Clinicians to attend a couple of sessions. If they felt comfortable, they could think about situations they have found difficult to understand within their work setting. I drew some attention to core psychoanalytic theory. I had no reason to think that the practitioners knew about psychoanalytic concepts. I decided that there were three points of theory that I would introduce, and these are:

- Transference and countertransference.
- Projections and interjections.
- The unconscious mind with the focus on the role of emotional defences.

I had to be careful and get the balance right. The drawback of bringing in theory is that it may dominate the Clinicians' minds and not encourage space to think about their experiential learning. The theory could be used as a defence to keep them away from difficult raw emotions; this could be counterproductive as one of the aims of a WDG is to help Clinicians think about the raw emotions they experience within their work setting and help them acknowledge manage and live through these difficult experiences. The positive aspect of introducing psychoanalytic theory is that it gives the Clinicians something to hold onto to help hold their thinking together. It would be very different to run a WDG for participants who have many other opportunities outside the WDG to think about what they may be experiencing in a WDG; for example, in a psychoanalytic psychotherapy clinical training course linked to personal analysis, there would be a lot more opportunities to think.

Stage 3. **Observe**: I would suggest the session had to feel non-judgmental and non-threatening and emphasise several practical examples of how past Clinicians had found attending a WDG beneficial and challenging. The need to be sensitive to Clinicians' emotional histories was more present in my mind, and to be aware of individual personality differences within the setting.

Stage 4. **Reflection**: What has been more reinforced within my thinking has been the bespoke nature of the environment and providing enough space for the WDG to have an atmosphere all of its own linked to the nature of stimulating curiosity as a process of developing thinking

Conclusions

The bespoke nature of the WDG was about bridging the participant's unique expertise with an opportunity to gain new insight. It was evident from my research that in the first WDG, there was confusion that lasted for the first several sessions about psychoanalytic concepts and how they could relate to the clinician's working environment. How Clinicians can be assisted in gaining psychoanalytic insight into human relationships was alive in my practice. At one end of the spectrum, some authors believe psychoanalytic insight can only be genuinely understood and gained if the person has an analysis alongside clinical training. However, at the other end of the scale, authors such as Bower (2005) believe psychoanalytic understanding can help professionals manage the complexities of their work.

The author and psychoanalyst Symington (1986) discusses learning from the outside with a focus on teaching compared to more profound learning from the inside "intrapsychic" with more of a focus on experiential learning, which could help to gain a better understanding of one's practice.
In future WDGs, I would need to continuously reflect that I am not just teaching the Clinicians as I want them to learn from experience. For example, Symington (2012) discussed how important intrapsychic self-awareness is in relationships.

"Interpersonal refers to the way in which one human being relates to another. Intrapsychic refers to the way in which the different parts within the personality connect to each other.
The way in which a human being relates to another is mirrored by the manner in which different parts within the personality relate to each other. The interpersonal and the intrapsychic correlate with each other" (p. 398).

With the focus on self-awareness, do practitioners who have had limited exposure to psychoanalytic concepts feel helped, or could it be that particular Clinicians find it more destabilising. What goes on in someone's mind that has a core profession but is not psychoanalytically trained could limit the benefits of the WDG. A WDG may be viewed as a problematic experience requiring Clinicians to review their practice.

Study limitations

This research could have been strengthened, allow the research is rich it is personal, but I also could have been mistaken in some of my observations. A limitation of the study is the transferability. Transferability can be strengthened by providing readers with evidence that the research study's findings could be applicable to other WDGs. Transferability may sound tricky and wish-washy, but Lincoln & Guba (1985) said it best. "It is, in summary, not the researcher's task to provide an index of transferability; it is his or her responsibility to provide the data that makes transferability judgements possible on the part of potential appliers" (p. 316). I have had this experience with this group, but how do we know that every facilitator would have similar experiences of WDGs. This is hard to tell from such a small, limited data set. Transferability could not be confirmed as there is no evidence that this research study's findings could apply to other WDGs.

A limitation was that I was reasonably new to the facilitation of WDGs. At times in the early sessions, it may have been hard to separate my anxiety from the anxiety that may have been activated within the group; this may have been linked to my limited experience in setting up and facilitating WDGs. The study was also set within a specialist team which could be seen as limiting as the Clinicians were primarily responding to C/YP in crisis. Would the WDG be as helpful in a CAMHS team that may not have been so challenging.

Suggestions for further research

This was a piece of subjective research which has both strengths and weaknesses. As Braun and Clarke (2006) highlight, pros can be that a systematic analytic engagement with the data can provide extremely insightful data. Cons are a low level of reliability and a high level of biases with an inability to generalise research findings. What could strengthen the research in the future is that I could have a co-researcher either run the WDGs with me and analyse the data with me, or join me for one of those two tasks: this would provide someone else to reflect on the experience and provide

feedback from another line of sight. This has been referred to as “Investigator triangulation” Denzin (1970), cited in Veronica (2001) and involves using more than one observer, interviewer, coder, or data analyst in the study. Confirmation of data among investigators, without prior discussion or collaboration with one another, lends greater credibility.

In a different enquiry about WDGs in the future, it could be helpful to interview the Clinicians and gather and analyse data on their experiences of attending WDGs. This would help illuminate the differences between being a member of a group and being a facilitator. The ideas about what different people find helpful would be interesting to draw out.

Just as this study has focused on offering a WDG in a specific setting (crisis team), other studies could explore different settings (for example, clinicians from specialist mental health teams for children suffering from eating disorders or children wanting to think about their gender). A cross-setting review could helpfully think about common factors between many WDGs, and identify challenges specific to each.

REFERENCES

Altrichter, H., Kemmis, S., McTaggart, R. and Zuber-Skerritt, O., (2002). The concept of action research*. The learning organization.* pp 125-131.

Angela, F., Dr Vega Zagier, R. and Vega Zagier, R. (1998) *Managing Mental Health in the Community: Chaos and Containment.* London: Routledge.

Bankes, N. A. J. C. (2002). *Unconscious processes in practitioners who work therapeutically with children and young people who sexually abuse*. University of Sussex.

Beck, A. (2014) *'Staff stress, change and the NHS'*, *Clinical Psychology Forum,* (263), pp. 34.

Bion, W. R. (1984) *Learning from experience. [electronic resource]. Karnac E-Books Series*: London: Karnac, 1984.

Bion, W. R. (2001) *Attention and interpretation. [electronic resource] : a scientific approach to insight in psycho-analysis and groups. International behavioural and social sciences library : psychology: 4*: Oxon [England] : Routledge, 2001.

Bion, W.R., (1967). Notes on memory and desire. *Classics in psychoanalytic technique*, pp.259-260.

Bower, P. and Gilbody, S., 2005. Stepped care in psychological therapies: access, effectiveness and efficiency: narrative literature review. *The British Journal of Psychiatry*, *186*(1), pp.11-17.

Boyatzis, R. E. (1998) *Transforming qualitative information. Thematic analysis and code development.* Sage Publications.

Bramley, W. (1990) 'Staff Sensitivity Groups: A Conductor's Field Experiences', *Group Analysis,* 23(3), pp. 301-316.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology, *Qualitative Research in Psychology,* 3(2), pp. 77.

Braun, V. and Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative research in sport, exercise and health*, *11*(4), pp.589-597.

Braun, V. and Clarke, V. (2020) 'Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches', *Counselling & Psychotherapy Research,* 21(1), pp. 37-47.

Brown, L. (1996) 'Pearlman, Laurie A., & Saakvitne, Karen W. (1995). Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors.New York: W.W. Norton, pp.451.

Clarke, V. and Braun, V. (2013) 'Teaching thematic analysis', *Psychologist,* 26(2), pp. 120-123.

Clarke, V. and Braun, V. (2018) 'Using thematic analysis in counselling and psychotherapy research: A critical reflection', *Counselling & Psychotherapy Research,* 18(2), pp. 107-110.

Corbin, J. and Strauss, A. (2008) *Basics of qualitative research: Techniques and procedures for developing grounded theory, 3rd ed.* Thousand Oaks, CA: Sage Publications, Inc.

Denzin, N. K. and Lincoln, Y. S. (2000). Handbook of Qualitative Research. *2nd edition* edited by Norman K. Denzin and Yvonna S. Lincoln. Sage, Thousand Oaks, 2000.

Etherington, K. (2004) *Becoming a reflexive researcher. Using ourselves in research.* Jessica Kingsley.

Etherington, K. (2017) 'Personal experience and critical reflexivity in counselling and psychotherapy research', *Counselling & Psychotherapy Research,* 17(2), pp. 85-94.

Fagan, M. (2011) 'Relational trauma and its impact on late-adopted children'. *Journal of Child Psychotherapy*, 37:2, 129-146.

Foskett, J. (2013) 'John Ballatt and Penelope Campling, Intelligent Kindness: Reforming the Culture of Health Care. London: RCPsych Publications, 2011, 224 pages (Pbk).

Foster, A. and Roberts, V. Z. (1998) *Managing mental health in the community. [electronic resource]: chaos and containment.* Routledge.

Fryer, D. *Doing Qualitative Research Differently: Free Association, Narrative and the Interview Method Holloway, W. and Jefferson ,T. (2000) Sage, London, 166pp, ?15.99 ISBN 0-7619-6426-6).* John Wiley & Sons Ltd. 1996.

Garland, C. (2002) *Understanding Trauma : A Psychoanalytical Approach. Tavistock Clinic Series* London: Routledge.

Garland, C. (2010) *The Groups Book: Psychoanalytic Group Therapy: Principles and Practice. Tavistock Clinic Series* London: Routledge.

Goldstein, D. J., Smith, K. B. and Waldrep, E. E. (1986) 'Factor analytic study of the Kaufman assessment battery for children', *Journal of Clinical Psychology,* 42, pp. 890-894.

Gray, C. M. and Siegel, M. A. (2014) 'Sketching Design Thinking: Representations of Design in Education and Practice', *Design and Technology Education,* 19(1), pp. 48-61.

Groarke, S. (2020) 'Freud and the remembered past', *American Imago,* 77(2), pp. 277-308.

Halsey, M. (2018) ' Child victims as adult offenders and the Criminogenic effects of unresolved trauma , *British Journal of Criminology,* 58(1), pp. 17-36.

Halsey, M. E. (2014). Correlates and predictors of burnout and secondary traumatic stress in mental health professionals. University of Southampton.

Hanley, B. (2016). The impact of organisational change on professionals working within a Community Mental Health Team (CMHT) : a psychodynamic perspective. Staffordshire University.

Harris, M. (2011) *Chapter One: The Tavistock Training and Philosophy (1977).* London : Karnac .

Holloway, I. and Todres, L. (2003) 'The status of method: flexibility, consistency and coherence', *Qualitative Research,* 3(3), pp. 345-357.

Hollway, W. and Jefferson, T. (2000) *Doing qualitative research differently. Free association, narrative and the interview method.* Sage.

Hover-Reisner, N., Fürstaller, M. and Wininger, A. (2018) ''Holding mind in mind': The use of work discussion in facilitating early childcare (kindergarten) teachers' capacity to mentalise', *Infant Observation,* 21(1), pp. 98-110.

Hunt, L. 2020. "You absorb trauma, without noticing it" : a qualitative exploration of staff experiences and subjective well-being working in CAMHS inpatient services. University of Essex.

Immy, H. and Les, T. (2003) 'The Status of Method: Flexibility, Consistency and Coherence', *Qualitative Research,* 3(3), pp. 345-357.

Jackson, E. and Klauber, T. (2018a) 'New developments: training in the facilitation of work discussion groups'. *Infant Observation,* 21:2, 241-260.

Jackson, E. and Klauber, T. (2018b) 'New developments: training in the facilitation of work discussion groups'. *Infant Observation,* 21:2, 241-260.

Kahr, B. (2011) 'Winnicott's 'Anni Horribiles': The Biographical Roots of 'Hate in the Counter-Transference'', *American Imago,* 68(2), pp. 173-211.

Kelly, R. R. (2013) 'FieldWorking: Reading and Writing Research (4th Edition)', *Mid-Western Educational Researcher,* 25(3), pp. 69-73.

Kets de Vries, M.F., Hellwig, T., Vrignaud, P., Guillen, L., Florent-Treacy, E. and Korotov, K.(2009). Sustainable effectiveness of a transformational leadership development program: An exploratory study. *INSEAD Business School Research Paper*, (2009/34).

Klein, M. (1988) *Love, guilt and reparation and other works 1921 - 1945. The Writings of Melanie Klein, Vol. 1*: London Virago Press 1988.

Klein, M. (1989) *The Oedipus complex in the light of early anxieties (1945).*

Klauber, T. (2016). First international conference on work discussion Vienna from 10 to 12th June 2016: Let's talk about work! Work discussion in practice and research. *Infant Observation*, *19*(2), pp.171-175.

Lainson, K., Braun, V. and Clarke, V. (2019) 'Being both narrative practitioner and academic researcher: A reflection on what thematic analysis has to offer narratively informed research', *International Journal of Narrative Therapy & Community Work,* (4), pp. 86-98.

Lees, A., Meyer, E. and Rafferty, J. (2013) 'From Menzies Lyth to Munro: The Problem of Managerialism', *British Journal of Social Work,* 43(3), pp. 542-558.

Lincoln, Y.S. and Guba, E.G., (1985). *Naturalistic inquiry*. sage.

Long, P. S. and Lepper, G. (2008) 'Metaphor in Psychoanalytic Psychotherapy: A Comparative Study of Four Cases by a Practitioner-Researcher', *British Journal of Psychotherapy,* 24(3), pp. 343-364.

Main, T. F. (1957) 'The ailment', *British Journal of Medical Psychology,* 30, pp. 129-145.

Marks, D. (1995) 'The Unconscious at Work: Individual and Organizational Stress in the Human Services edited by Anton Obholzer and Vega Zagier Roberts. Published by Routledge, London, 1994; 224 pages', *British Journal of Psychotherapy,* 11(3), pp. 482-484.

Mendelsohn, E. (2007) 'Analytic Love: Possibilities and Limitations', *Psychoanalytic Inquiry,* 27(3), pp. 219-245.

Moore, M. (2018) 'Work discussion as a method for supporting peripatetic teachers of vulnerable children', *Infant Observation,* 21(1), pp. 88-97.

Murray, J., (2011). Work discussion: *Learning from reflective practice in work with children and families*. Journal of Psychoanalytic psychotherapy 11(3) p. 18-19

Nowell, L. S., Norris, J. M., White, D. E. and Moules, N. J. (2017) 'Thematic Analysis: Striving to Meet the Trustworthiness Criteria', *International Journal of Qualitative Methods,* 16(1), pp. 1-1.

Price, H. and Cooper, A., 2012. In the field: Psychoanalytic observation and epistemological realism. In *Infant Observation and Research* (pp. 71-82). Routledge.

Pick, I. B. (2011) 'Discussion of 'Interpretation and Play'', *Psychoanalytic Study of the Child,* 65, pp. 169-174.

'R.D. Hinshelwood, (2001) *Thinking About Institutions. Milieux and Madness.* London: Jessica Kingsley Publishers.

Ramsden, E. (2014) A practitioner-researcher inquiry into choice, voice and agency in individual dramatherapy sessions : co-researching with children in a primary school setting. Leeds Beckett University.

Ramsden, S., Waggett, N. and Shuttleworth, J. (2010) 'Work discussion: learning from reflective practice in work with children and families', *Journal of Child Psychotherapy,* 36(1), pp. 85-92.

Richard, M. B. and Robert, M. (1987) 'The peer supervisory group for psychoanalytic therapists. *Journal of psychoanalytic Psychotherapy, 11(1), pp. 35-46.*

Rustin, M. and Bradley, J. (2008) *Work discussion. Learning from reflective practice in work with children and families.* London, Karnac, 2008.

Sherry, E. (2013) 'The vulnerable researcher: facing the challenges of sensitive research', *Qualitative Research Journal (Emerald Group Publishing Limited),* 13(3), pp. 278-288.

Smith, B. and Sparkes, A. C. (2012) 'Making sense of words and stories in qualitative research: Strategies for consideration', in Tenenbaum, G., Eklund, R.C. and Kamata, A. (eds.) *Measurement in sport and exercise psychology.* Champaign, IL: Human Kinetics, pp. 119-129.

Smith, J. A. (1996) 'Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology', *Psychology & Health,* 11(2), pp. 261-271.

Staite, E., Howey, L., Anderson, C. and Maddison, P. (2021) 'How well do children in the North East of England function after a crisis: a service evaluation', *Mental Health Review Journal,* 26(2), pp. 161-169.

Stokoe, P. (2021) *The Curiosity Drive. Our Need for Inquisitive Thinking.* Phoenix Publishing House.

Strauss, A. L. and Corbin, J. (1998) *Basics of qualitative research. Techniques and procedures for developing grounded theory.* Thousand Oaks CA, London Sage 1998

Trelles-Fishman, A. (2019a) 'Towards emotional containment for staff and patients: developing a Work Discussion group for play specialists in a paediatric ward', *Journal of Child Psychotherapy,* 45(1), pp. 4-17.

Trelles-Fishman, A. (2019b) 'Towards emotional containment for staff and patients: developing a Work Discussion group for play specialists in a paediatric ward', *Journal of Child Psychotherapy,* 45(1), pp. 4-17.

Veronica, L. and Petra, J., (2001). Exploring consumer evaluations of e-services: a portal site. *International Journal of Service Industry Management*, *12*(4), pp.359-377.

Von Unger, H. (2021) 'Ethical Reflexivity as Research Practice', *Historical Social Research,* 46(2), pp. 186-204.

Waddell, M. (2002) *Inside Lives: Psychoanalysis and the Growth of the Personality. Tavistock Clinic Series* London: Karnac Books.

Ward, A. (2002) 'Observing Organisations: Anxiety, Defence and Culture in Health-care edited by R. D. Hinshelwood and Wilhelm Skogstad (Routledge, London, 2000). pp. 178-183.

Weintrobe, S., 2004. Links between grievance, complaint and different forms of entitlement. *The International Journal of Psychoanalysis*, *85*(1), pp.83-96.

Whittaker, A. (2011) 'Social defences and organisational culture in a local authority child protection setting: challenges for the Munro Review.', *Journal of Social Work Practice,* 25(4), pp. 481-495.

Winnicott, D. W., Winnicott, C., Shepherd, R. and Davis, M. (2010) *Psycho-analytic explorations. [electronic resource]. Karnac E-Books Series*: Karnac Books.

Winnicott, D.W. and Britton, C., 1947. Residential management as treatment for difficult children: the evolution of a wartime hostels scheme. *Human Relations*, *1*(1), pp.87-97.

Willig,C, & Stainton Rogers, W. (2017). 7th Edition, *Handbook of Qualitative Research in Psychology*: Vol. Second edition. SAGE Publications Ltd.

Zacharia, E. (2020) *Creating a link between CAMHS and children's centres in a deprived area: A case of setting up a Work Discussion Group.* Thesis, [Online] Available at: Available at: https://tavistockandportman.nhs.uk

Appendices

Appendix A: Acronym List

Clinician – A staff member of the CAMHS Crisis & Intervention Assessment Team	(C)
Crisis Intervention & Assessment Team	(CAIT)
Facilitator's Reflection (F's-R) based on the facilitator's experience, which I recorded directly after the WDG session in Column 5.	(F's- R)
Work Discussion Group	(WDG)
The Child & Adolescent Mental Health Service	CAMHS
Reflective Thematic Analysis	(RTA)
Thematic Analysis	(TA)
Line number from field notes.	(L)
Session number	S

Appendix B

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699

https://tavistockandportman.nhs.uk/

Andrew McGibbon

By Email

01 October 2018

Dear Mr McGibbon,

Re: Research Ethics Application

Title: What are my experiences as a Trainee Child Psychotherapist, setting up and facilitating a Work Discussion Group for clinical staff in a CAMHS setting?

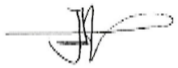
I am pleased to inform you that the Trust Research Ethics Committee formally approved your application on 1st October 2018.

If you have any further questions or require any clarification do not hesitate to contact me.

Please note that I am copying this communication to your supervisor for information.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,



Paru Jeram
Secretary to the Trust Research Degrees Subcommittee
T: 020 938 2699
E: pjeram@tavi-Port.nhs.uk

cc. Course/Research Lead, Supervisor, Course Administrator, Academic Quality

Appendix C

The Tavistock and Portman NHS
NHS Foundation Trust

HSC Belfast Health and Social Care Trust
caring supporting improving together

Participation Information Sheet

As a member of the CAMHS Work Discussion Group that I facilitate, I am inviting you to take part in a new research study. This Information Sheet describes the study and explains what would be involved if you took part.

What are my experiences as a Trainee Child Psychotherapist, setting up and facilitating a Work Discussion Group for clinical staff in a CAMHS setting?

What is the purpose of this study?

In this study, I will be exploring my experience of setting up and facilitating a Work Discussion Group. As well as developing my own practice through close reflection, I will be trying to understand the underlying processes that bring about helpful experiences in these groups and make a contribution to my professional understanding about this work.

Who is conducting the study?

My name is Andrew McGibbon. I am in the second half of my doctoral-level clinical training in psychoanalytic Child and Adolescent Psychotherapy at the Tavistock and Portman Foundation (NHS) Trust.

What will participating in this study involve?

If you agree to participate, I will invite you to attend the WDG. I will be using Field Notes to reflect and record my experience of the WDG, which will be influenced by your attendant and will help me understand my own experience. Because of this, all information will be anonymised. The WDG session will be offered weekly, lasting 75 minutes.

Do I have to take part?

No, it's completely up to you whether or not you take part in this study. Your membership of the ongoing WDG is not affected either way. If you agree to take part in and later change your mind, you can do so at any time without giving me a reason. At the end there will be a further two-week 'cool-off' period. After two weeks, I will start the analysis process of the data as a whole set, and it will no longer be possible to remove individual contributions.

What will happen to any information I share?

I will receive and manage any information you share with me as confidential and take steps to maintain your privacy. Your name and contact details will be kept separately from my Field notes, and any details that could be used to identify you will be removed from it. Any quoted directly in my written work will be anonymised. All electronic data will be stored on a password-protected computer. Paper copies of work-in-progress will be kept in a locked filing cabinet to which I have sole access. I will discuss this material with my appointed research supervisors during the preparation of my thesis;

these colleagues will take the same care to maintain the proper confidentiality of the research material. While I will take all possible steps to ensure your anonymity because the project investigates a specialist service that only a relatively small group of professionals might have contact with, this limits the degree of absolute confidentiality that can be guaranteed.

What will be done with the results of the project?

A copy of my final thesis will be filed at my institution. I may also present my findings at professional meetings or conferences and prepare articles for publication. If I do this, any examples from our work that I include as illustrative evidence will be chosen to maximise confidentiality and anonymity. If you are interested, I will be happy to send you a summary of my thesis once it is completed.

What are the possible benefits of taking part?

There will be no immediate significant benefit for you. You may find it interesting to reflect on your experience of being a member of the WDG . By taking part in this study, you may be helping to develop the knowledge and understanding of how to arrange future Work Discussion Groups successfully.

Are there any risks?

Reflecting on and discussing work-related emotional issues may give rise to difficult feelings, which you are invited to bring back to the ongoing group. If you become concerned about any work-related emotional issue that has been amplified, please let me know, and I will signpost you to sources of professional support. The Belfast Health and Social Care Trust offers a support service for all staff via : staffcare@belfasttrust.hscni.net .Contact details

Researcher: Andrew Mc Gibbon
Tel: 02892 501265
E-mail: andrew.mcgibbon@belfasttrust.hscni.net

The Child and Adolescent Mental Health Service
Belfast Health & Social Care Trust
91 Hillsborough Rd
LISBURN
BT 28 3JA

Research Supervisor: Dr Brinley Yare
Tel: 020 7425 2155
Email: byare@tavi-port.ac.uk

The Department of Education and Training
The Tavistock Centre
120 Belsize Lane
LONDON
NW3 5BA

Advice that if participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

You are also welcome to contact Brinley Yare with any queries about the management of this research project. Dr Yare is a member of the teaching staff at the Tavistock & Portman NHS Foundation Trust where I am training.

Appendix D

The Tavistock and Portman NHS

NHS Foundation Trust

Consent Form

What are my experiences as a Trainee Child Psychotherapist, setting up and facilitating a Work Discussion Group for clinical staff in a CAMHS setting?

Andrew McGibbon / DProf research project

Thank you for agreeing to take part in this study. Once you have had chance to read the Information Sheet and ask any further questions, please complete this Consent Form by ticking each statement and signing. I will file a copy as confidential material and provide you with a copy too.

I confirm that I have read and understand the information sheet provided for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

I understand that my participation in this study is voluntary. I am free to cancel or not attend my scheduled WDG without giving a reason and continue as a regular member of the ongoing Work Discussion Group irrespective of that change of plan. Once the WDG is ended, you will have a further two-week period to ask that my material be excluded from the study. After that period, I understand that my anonymised material will be available for inclusion in the study, as it will not then be possible to identify and remove my material from the total data set being considered.

☐

I understand that any personal data that could be used to identify me will be removed from the Field notes and that all steps will be taken to ensure that I could not be identified as a participant in this study in any future publication, report or presentation. However, because the project investigates a specialist service that only a relatively small group of professionals might have contact with, this limits the degree of absolute confidentiality that can be guaranteed.

☐

Participant's name (printed):----------

Participant's signature:----------

Appendix E

Example of **raw data (Field Notes)** from session 1, recorded immediately after the session before), before moving into four columned structured Field Log/Notes. (The writing in bold and encased in brackets is my immediate reflection to my experience.

Stage 1. Meeting the crisis team and CAMHS manager and clinical Lead

The Clinical Director is a Consultant Psychiatrist who was also in the room. (**Anxious being interviewed)**. At this stage, there were five staff (**unstable, people coming in and out**) members in the room. The team leader-(**approval- gatekeeper)** said I could start as she wasn't sure (**nothing sure, unstable)** if any more people would be joining –(**making a connection)-** and some people might have to leave early**-(unstable)**- to go and carry out a crisis assessment –(**to be moving not to stand still)**- that was booked –(**unprotected time, who owns the time-)**, in for them to see at 12.00. (**unstable setting, environment).** At this time, another staff member entered the room- (**no meaning of time-busy)-** and came over and sat down beside me –(**needing to feel safe)-** and said hello**-links-** and mentioned my name –(**History)-**. I mentioned his name as I had known him from working with a C/YP.–(**nothing new from the past, establishing newness)-**. **past present, conflicting roles, how they see me)** At this stage, I had nine staff members in the room.

I started by thanking -(**power- powerlessness)-** them for coming and said that I was exploring -(**shared experience)-** staffs interests in -**exploration-** becoming part of a work discussion –(**breaking out, leaving -joining a new group)-**. group. The group would be linked to carrying out some research –(**give and take process)-** about staff's experiences of attending the group in reflection of my experience of running the group. I used the word work discussion group –(**discussion, two-way process)-.** and said it was a model that had been shown to be helpful –(**wanting to be accepted)-** in helping staff work with patients that are in emotional distress. (**Painful, better to push away-push me away, what do I bring, what do I ask. Pushing painful feelings away. Open to listening).**
I mention the history of the work discussion groups (**foundation roots surviving the storm)**, as it initially started as a training method, but then it was brought out and used in lots of different work settings – educational, social services, palliative care nurses and within special behavioural schools. I spoke about how the structure –(**holding together)-** of the group would be voluntary (**in and out the door),** and nobody would be told to attend –(**authority, what is it, how does it work)**.

I mentioned how each group was different and was shaped by the individuals –(**self-expression, witness)-** that attended, but there were some common themes –(**making links with colleagues- a place to let go of different viewpoints with and from colleagues)-.** Where we would be picking and looking at not the whole case per se, but an interaction –(**freedom to choose aspects of the work, giving direction)-** something that the clinician may feel that they would like to explore more –(**non-directed, but gentle direction-guidance -something new)-.** I said that in some cases, staff can write up –(**challenge of putting your thoughts on paper-** material and present it -**words held in time-on paper)-**. In other cases, it may not be practical –(**sense of freedom to think)-**, but the main aim is not to focus on the whole case or review the whole case but to think about your interaction –(**opportunity to learn to self-reflect)-** and what you experience and to bring some space- (**how do you use the space, stimulate interest)-**.

Appendix F: Example of Field notes from Session 1

The Team meeting: Took place in the mini-conference room setting. I arrived preparation a few minutes early – and went up to the office about 11.25 am and nobody was in the room.					The necessity of providing a reliable predictable space and time. Setting the scene b 1
1) What happened? The verbal content. (All verbal content will be in *italics*)	2) **My emotional experience as a researcher and facilitator within the Work Discussion seminar. 1)What happened?**	**3) Why did I think it happened?**	**4) Learning What did I learn? What could I do the next time? What did I do during the seminar?**	**Facilitator's reflections as a lead into coding, just before starting coding.**	**Codes.**
1. At the agreed time as confirmed by email with the Team Leader (TL, Manager(M) and Clinical Director (CD) the researcher was waiting in the room on his own. After 5 minutes, the team leader came into the room and said:	Feeling of isolation. Excitement hopeful, fear, gentleness but robustness.	Limited space, low down the priority list on people's minds.	A sense of a room full of busy mines.	1. A sense of being left on my own. 1.2. A sense of limited space for people to think. 1.3. A sense of being low down the priority list.	Offering is not taken up directly. We need a management bridge into this novel space. A sense of isolation all eyes on me.
2. Team leader (TL): *Hello, they should be here soon; I told them they had to come .The team meeting run over, we had lots of new referrals to talk about.*	Pressure fitting things in.	Busy, and I adding or taking away to the atmosphere.	No need to panic, staying focused.	2. The team is too busy to be here on time. 2.1. A sense of pressure both external and internal. A sense of critical judgement	Explanation offered for late arrival. We are very busy conflicting calls on limited attention.
3. Facillitator (F): *ok, I have an hour booked out, I can wait, I*	Wonder, not feeling valued or wanted. Not my fault.	Do I feel like a new referral in the TL mind.	Being on time. Being serious and professional .	3. The researcher needing to be flexible but maintain	Burden or help.

appreciate having this opportunity to talk to the team.				a sense of robustness. 3.1 Promote a sense of wondering feeling undervalued	
4.More staff came into the room. Manager (M) for CAMHS came into the room first. The researcher said hello to each person as they entered the room. Some of them were, texting and looking at their phones. The group was also joined by a staff grade Psychiatrist within the team and the Clinical Director (CD) who by profession is a Consultant Child & Adolescent Psychiatrist. By now 9 people involved with the crisis service were in the room.	Thinking, holding in mind. Space. Feeling on the outside.	I thought about the staff and wondered what they would be bringing into the group meeting- collective minds- from their other meeting. Getting parental permission.		4.The researcher has an audience. 4.1The need to keep the thinking clear. 4.2Holding the team in mind. 4.3The need for silence and space. 4.4A sense of feeling very much on the outside of the team.	We need a management bridge into this novel space. Individual attention as an aspect of a friendly welcome. We are all very busy conflict in calls limited attention. This offering has attracted a lot of attention in the senior management team.
5.T L: *You better start, as I am unsure if any more people will be joining, and some people might have to leave early, as*	Approval gate keeper. nothing sure, unstable anxious being interviewed. People coming in	Pace, the meaning of time and who owns time. Outside needs to know who the boss is and		5.1 Being told what to do. 5.2The sense of the team lead as a gatekeeper.	Invite or instruction he is in charge We are all very busy conflict in calls limited attention

they have to go and carry out a crisis assessment that was booked in for them to see at 12.00pm.	and out members in the room. Connection. Time pressure. To be moving not to stand still. Unprotected time, who owns the time.	how words and actions may not link up.		5.3A sense of not feeling sure that anyone will attend the group.	

Session: Last session. Background of the patient.

C 1 brought a write up of a male patient called A aged 15. Anthony had been discharged from an inpatient unit two weeks ago after a 12-week admission. Preceding this admission A had tried several times to hang himself and cut his throat and face on several occasions, these cuts required minimal medical treatment. A's second weekend home he had taken an overdose of 40 tablets. He told his mother after he started to feel physically sleepy and his mother called 999. A was admitted to a medical ward for overnight observations. The following day the CAMHS crisis team were asked to assess A as he was deemed medically fit for discharge.

The Final phase.					
Experience What happened? **Spoken words**	**My emotional experience as a facilitator within the Work Discussion seminar.**	**Reflection Why did I think it happened? What did I notice in the seminar room?**	**Learning What did I learn? What could I do the next time? What did I do during the seminar.**	**Personal reflections as a lead into coding, just before starting coding.**	**Codes**
1. Facilitator (F). *As we have been counting down the last couple of months to today being the last session, I just want to say I have found facilitating the WD enjoyable, interesting and on occasions challenging. I hope you have also found it interesting.* *I am aware today that C 1 has some clinical work they want to*	Keeping the focus on the ethos. Feeling emotional and not wanting to let go of the WD.	I have invested a lot in getting the WD of the ground and all the different aspects of researching the experience.	I should have planned a focus group after the ending.	The final process in ending the WD.	The ending is real and the countdown is over. The F mentions his experience as being enjoyable, interesting, and challenging. Experience have value and meaning.

present in the WD.					Working as to chatting, the ethos over the personalities

2. C1. *The WD time has gone so quickly and to my surprise I have wound , sorry I mean found it helpful in lots of ways. Sorry, I meant to say I have found it helpful.*	Wondering about the slip of the tongue around the words regards, wounds as to found.		In a sense does the end of the group feel like a wound.	A space to think about wounds.	All words have meaning, and The (F) likes words, *"wound"* and "*found"* can say something important.
3. Silence	Maybe today's session is about moving on from some wounds to a less wounded place.			Helping the wounds be thought about has been a big part of the WD.	
4. F. *Maybe the word wounds you used was not an absolute mistake, in some ways the WD has been about thinking about wounds and what we have shared during the WD.*	A sense of a shared experience of wounds and healing.			Feeling more curious about the experience.	All words have meaning, and The (F) likes words, *"wound"* and "*found"* can say something important.
3. C3. *I personally did find it helpful but a bit confusing at times. Things that made no sense in the early sessions make more sense now, and I guess that is progress for an old hand like me.*	This WD group did not suit all the team members. The words personally, reminded the F of the individual nature of each person.	A sense of achievement.		A sense of being able to have a wild open space to think. A trusting space. Room for new experiences to be taken in.	The (F) as causing confusion which can mean growth or not. An experience of growth out of confusion.
4. Silence.	A sense of loss that some team members were unable to come			Losses and gains.	

	to this last session.				
5. C 3. *For me there was something about getting away from the normal team environment, just a different atmosphere. You could think about stuff in here that you would never mention in the weekly team meeting.*			I should have planned the ending in a more focused way. The three C's in today's session want to process the experience.	Able to leave things behind and come into a different space. Maybe in a way the group will not totally end for me until I complete my research.	The (F) linked into the WD providing an in-between place with a different atmosphere.

Appendix G: Working on line-to-line coding of selected WDG sessions.

1. A sense of being left on my own.

1.2. A limited space for people to think, stickiness .

1.3. A of being low down the priority list, lots of steps on this ladder.

1.4. A room full of busy mines, with no traffic lights.

1.5. A sense of isolation all eyes on me, its spotlight time.

1.6. An experience of hopefulness born out of past experiences, broken words stll have a story, if you can link it up.

1.7. A sense of fear, mostly a failure and wasting the team's time.

1.8. A sense of gentleness linked into a sense of my own robustness.

2. The team is too busy to be here on time; actions can speak louder than words.

2.1. A sense of pressure both external and internal.

2.3 I need to try and fit things in.

2.4. A sense of busyness.

2.5. A sense of me adding something to the atmosphere in the room.

2.6 .A sense of bringing focus with me.

2.7. A sense of panic.

2.8. .A sense of needing more focus.

3. The researcher needs to be flexible but maintain a sense of robustness.

3.1 Promote a sense of wondering feeling undervalued.

3.2 The atmosphere is not all my fault.

3.3. The never-ending demand/ Adding to the team's workload.

3.4. Being a new referral/ assessment never stops

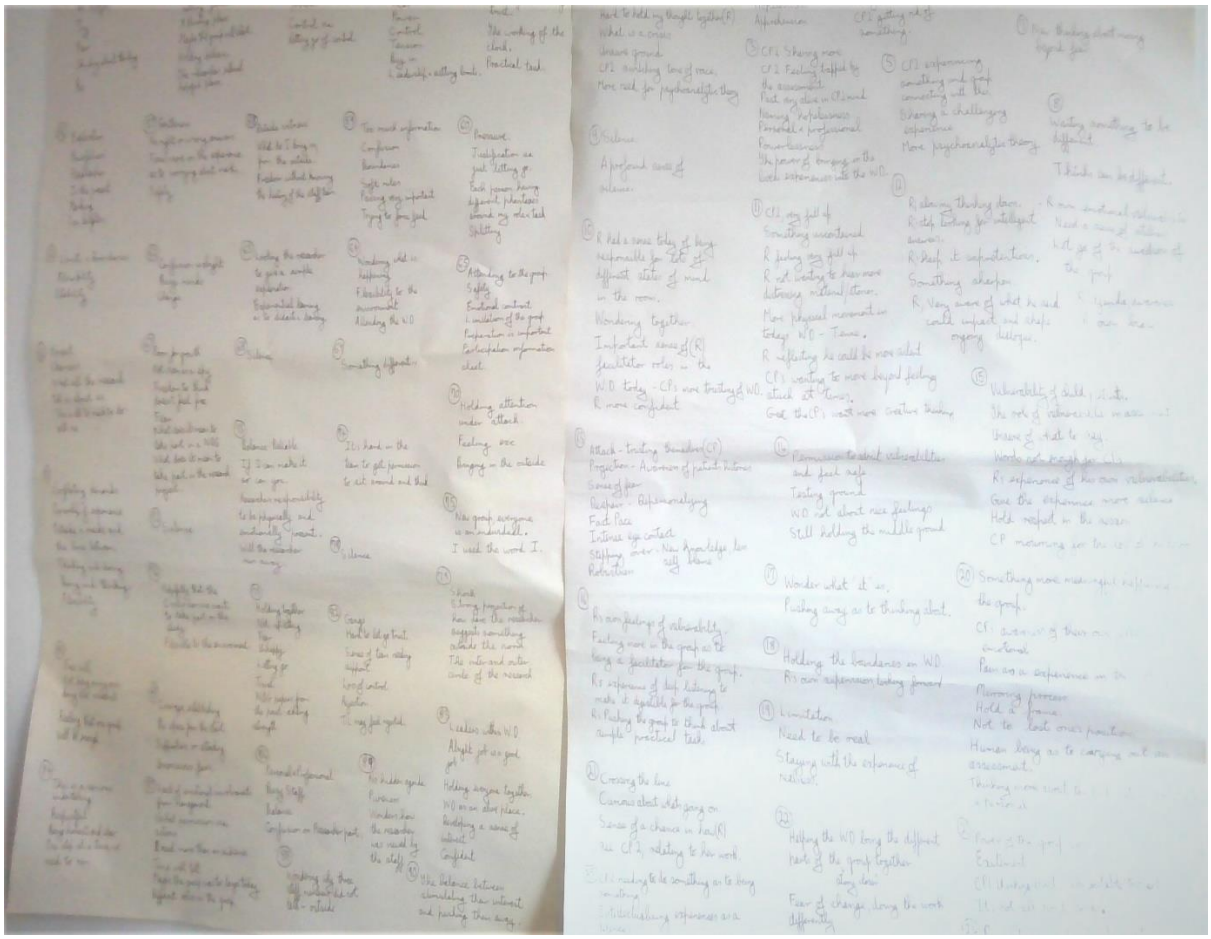
3.5. The importance of being on time. Mr Reliability is dependable.

3.6. A sense of needing to be in control of my own professionalism/mind.

Appendix H: Development of Themes

Themes	Codes
Hostility & Rivalry, at best a lukewarm handshake	The offer is not taken off directly. Line 1
	We are very busy with conflicting calls on limited attention. Line 2
	Burden or help. Line 3
	We are all very busy conflict and calls limited attention. Line 4
	Invite our instruction who is in charge. Line 5
	We are all very busy conflict and calls limited attention. Line 5
	Your agenda or ours. Line 11
	Four questions were asked, straight in a row, with little space to answer. This is exactly? Hostility?
	WHY US? “ARE WE BEING DONE TO HERE” Line 22.
	Realising that the Facilitator is being made to dance. Line 24
	The way the mind works equals just hostility to psychology and thinking. Line 28
	Confusion misunderstanding of what was happening with the time? Is this anxious? Hostility? Curiosity? Line 32
	Persecutory; forced against will. There might be something shady (unethical, unregulated) going on here. We do this for you; we are caught, and your research it is something for us (you get caught in our service) Line 39.
	Burden or helpful. Line 42
	Bargaining to get within the team. Friend or foe. Line 46
	Are we like each other or different? Perhaps we don't want to be like you. Line 49
	It’s very busy, no time or need to think, but maybe? Is this anxious? HOSTILE? Rivalry ? Line 62
	Ambivalence around taking part; BACK DOOR as an exit without looking like anyone is leaving. Line 64
	Why us? What will people think? Anxious? HOSTILE? Curiosity? Line 66.
	Hesitancy and uncertainty. Line 69
	Is there an exit strategy if we have a crisis? DILEMMAS around coming in. Line 71 &73.
	The needs of me, you, them who has control of time. Line 74
	Exclusion and inclusion, who is in or out. Not having a TL present, could turn hostile. Will the WD group play the normal tune. Line 79
	Friend or foe. Line 82
	Facilitator on trial. Line 86

Appendix I: Immersing myself in the data, working on the Themes and sub Themes.



Grouping themes/ongoing reflection/ interpretation with the 4 main Themes envolving.