

**‘Shifting between the internal and external’:
Psychoanalytic ways of working with children in local
authority care**

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Declaration

I, Fiona Robinson, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed: Fiona Robinson

Date: 05/08/2021

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Abstract

This thesis seeks to explore psychoanalytic ways of working with children in local authority care. Despite evidence suggesting psychoanalytic psychotherapy is used widely in routine clinical practice in the UK and may be helpful for children who experienced early attachment trauma, there is little research examining its use with these children. Study 1 aimed to identify current models of working with looked after and adopted children amongst UK psychoanalytic child psychotherapists. A survey of child psychotherapists (n=215) examined a range of activities, including assessment, therapy, work with foster carers/adoptive parents, and consultation to the professional network. Respondents placed emphasis on work with professionals and foster carers, seeing this as an area of development for services. Study 2 aimed to explore how child psychotherapists understood their work as consultant to the professional network, and what they saw as particular to the psychoanalytic approach. Thematic analysis of in-depth interviews (n=9) identified that participants experienced various tensions they held within themselves in their role, particularly around wanting to offer a network-led approach, when professionals often asked them to provide therapy. Study 3 aimed to understand how child psychotherapists function within a specialist children's social care setting, including how they positioned themselves in a multi-disciplinary Child and Adolescent Mental Health Service (CAMHS) and a multi-agency setting. Grounded theory analysis of an ethnographic case study identified that the child psychotherapists balanced three elements of their professional identity in this role: a discipline-specific identity; CAMHS team identity; and professional network member identity. To be effective in their role, the child psychotherapists needed to integrate the elements of their professional identity. Collectively, the findings have implications for understanding the role of UK child psychotherapists working with children in local authority care; particularly the significance, but also complexity, of work with the professional network around the child.

Impact Statement

Children in local authority care are widely recognised as a vulnerable population and are at increased risk for mental health problems compared to children living with birth families (Ford et al., 2007). There are large gaps in the evidence-base for what makes an effective clinical intervention with these children (NICE/SCIE, 2010). Clinical material suggests that psychoanalytic psychotherapy may be beneficial (e.g. Hunter, 2001), however the extent of its use and range of work conducted with UK children in local authority care was unknown. This thesis sought to understand psychoanalytic ways of working with these children, including the role of child psychotherapists.

The findings challenge how child psychotherapists are typically perceived; as primarily providing individual therapy. This thesis proposes that a core feature of their work in this field is consultation with the professional network and foster carers. This has implications for how child psychotherapy is understood and how services should be designed to meet these children's needs. This includes a model of working that begins with consultation-based services, and specific considerations when assessing suitability for therapy. These are that the child is in a stable placement and supported to attend therapy, and the service can offer the length of work required. When these conditions are not met, child psychotherapists may be better placed providing consultations to professionals or carers. These findings are a precursor to research assessing the impact of psychoanalytic consultation to professionals and foster carers.

The findings propose how agencies can best make use of child psychotherapists' input, particularly the attention child psychotherapists pay to the child's emotional life, connecting their internal and external worlds. The findings suggest that child psychotherapists offer a distinct model of reflective practice; understanding how professionals may protect themselves from feelings generated by the work, which create risks to the worker and organisational task. By thinking about these experiences through reflective practice, professionals can make sense of feelings aroused in the work.

The findings have implications for child psychotherapy practice and professional training. This includes how child psychotherapists can integrate into multi-disciplinary and multi-agency settings whilst maintaining their distinct

professional identity. To work effectively alongside social care, the profession needs an understanding of social cares' pressures, and tensions inherent between services in this field. Within both academic modules and clinical placements, training should include a core element of consultation to professionals and foster carers.

At a service delivery level, the research helps to understand benefits and challenges of co-located CAMHS and social services. Within UK mental health services, there is a shift towards routinely offering time-limited, once weekly sessions (Bent-Hazelwood, 2020), but a case study of a specialist CAMHS identifies benefits of a flexible approach to mental health casework with these children. This allows professionals to access mental health services with a rich understanding of a child's history, available for consultation even when therapy is not active. This is worth pursuing in future research to establish the feasibility of using this approach more widely within targeted services for children in local authority care.

Publications and presentations associated with this thesis

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1 Introduction

Children in local authority care are widely recognised as a highly vulnerable population, and are at an increased risk for a range of negative outcomes compared to children living with their family of origin (Ford et al., 2007). Prior to entering care, many of these children have experienced early abuse, maltreatment, or neglect (Department for Education, 2021a), and it is well known that traumatic experiences can significantly impact numerous domains of functioning (Ford, 2005; van der Kolk, 2005). There is a wealth of evidence suggesting children in local authority care are more likely to experience mental health problems than children living with birth families (Ford et al., 2007; Meltzer et al., 2003). However, the complexity of symptomatology displayed by many of these children can create additional challenges to meeting their mental health needs, including difficulties with assessment, diagnosis, accessing appropriate services, and identifying evidence-based treatments. The most effective clinical intervention for children in local authority care is currently unknown, and there is a pressing need for further research into interventions which effectively target these children's emotional wellbeing (Luke et al., 2014). This thesis focuses on one approach to mental health treatment with children, which has traditionally played a role in therapy and services in the UK, Europe and North America for many years – the psychoanalytic approach. This chapter will provide an overview of children in local authority care and the challenges to meeting their mental health needs; discussion of these factors provides the context and rationale for the research undertaken in this thesis. The chapter ends with an overview of the structure and research design of this thesis, which comprises three interlinked empirical studies, with an overall aim of exploring psychoanalytic ways of working with children in local authority care and the role of psychoanalytic child psychotherapists working in this field.

1.1 Children in local authority care

In the UK, the terms 'looked after children' or 'children looked after' are typically used by local authorities and in government documents to refer to children placed under the care of the local authority (Department for Education, 2021a). Globally, there exists various terminology to describe these children, including 'children in out-of-home care' in North America and Australasia (Tarren-Sweeney & Vetere, 2013). In this thesis, the term 'children in local authority care' will be primarily used. This term was chosen because it offers a description of the child's living circumstances (namely, that they are in the care of, and accommodated by, the local authority), but avoids the use of labels that may be experienced as stigmatizing, for example the acronym 'LAC' (for 'looked after child') (TACT, 2019). This is, however, with acknowledgement that the term does not necessarily use language preferred by care-experienced children and young people. Research by The Adolescent and Children's Trust (TACT), in collaboration with children and young people, identified that many preferred to be simply called by their name, or referred to as 'young people or children' or 'our children' by the local authority (TACT, 2019). However, within the academic context of this thesis, there is the need for acknowledgement of children and young people's living circumstances. Throughout the thesis, when a specific term is adopted by a particular service (such as LAC or looked after child), that term will also be used.

Across several western jurisdictions, the number of children in local authority care has steadily increased in recent years, including in the UK and Australia (AIHW, 2020; Department for Education, 2019). However, the latest figures from the Department for Education (2021) show a decrease in England of children starting to be looked after. As of March 2020, there were 80,080 children in local authority care in England. Since the end of the twentieth century, amongst many western countries there has been a move away from placing children in residential placements and instead towards foster care; however there is increasing emphasis on utilizing kinship care with family members or friends, or – particularly in the UK and North America – adoption from care, known as achieving 'permanence' (see Tarren-Sweeney & Vetere, 2013 for a discussion). The focus of this introductory chapter will be on describing children in local authority care in the UK context, given that the empirical studies in this thesis concern psychoanalytic work with children practiced

by UK child psychotherapists. However, this is with acknowledgement that children living in alternate care is a widespread occurrence internationally, and that a principal reason for being taken into care globally is experiences of trauma and maltreatment (Tarren-Sweeney & Vetere, 2013). International research is also included in this chapter where appropriate.

Under the UK Children Act 2004, there are several routes by which a child can become looked after, namely a care order (section 31), with voluntary agreement of the parents (section 20), an emergency protection order (section 44 or 46), or accommodated compulsorily, for example a criminal justice supervision order with a residence requirement (section 21). The majority of children in local authority care are placed in foster care, although children can also be placed in residential settings, kinship care, or independent living settings for older adolescents, or placed for adoption (Department for Education, 2021a). The most common reason for children becoming looked after is due to experiences of trauma or maltreatment, including physical, sexual, emotional abuse or neglect (Bazalgette et al., 2015). In fact, recent estimates show that the majority (65%) of children in local authority care in England are taken into care as a result of abuse and neglect (Department for Education, 2021a). Other reasons whereby children may enter the care system include: family dysfunction; the family being in acute stress; and loss or absence of the parents (Department for Education, 2021a).

It is widely recognised that children in local authority care have increased vulnerabilities for a range of negative outcomes compared to children not living in foster care (Ford et al., 2007). Children in local authority care are less likely to perform well at school compared to children living with birth families (Department for Education, 2021b). They also have higher rates of learning disabilities than even the most disadvantaged children living in private households (Ford et al., 2007). In 2020, 55.7% of children in local authority care continuously for 12 months had a special educational need, compared to 15.3% of all children in England (Department for Education, 2020b). The most recent statistics from the Department for Education (2020a) indicate that 11% of children in local authority care were reported missing from their placements, and there is evidence that a high proportion of children who experience sexual exploitation come from backgrounds of care, with children in residential placements particularly vulnerable (CEOP, 2011).

There is a wealth of evidence from population studies to suggest that children in local authority care are more likely to experience mental health difficulties than children living with birth families (Ford et al., 2007; Meltzer et al., 2003). Although rates vary depending on location (Oswald et al., 2010), in the UK, a large survey carried out by the Office for National Statistics found that 45% of children in local authority care aged 5-17 were assessed as having at least one mental disorder, although this study is nearly twenty years old now (Meltzer et al., 2003). Among the 5-15 year olds, this rate was between four to five times higher than children living with birth families, with conduct disorders accounting for the largest proportion of difference. The rate of mental disorders amongst children in residential care was even higher, with nearly three quarters assessed as having a disorder. Children in local authority care also have high rates of internalizing disorders, including anxiety, post-traumatic stress disorder (PTSD) and depression (Ford et al., 2007). The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), a screening tool assessing emotional and behavioural problems amongst children, is used to assess and monitor the mental health of children in local authority care in England and Wales; the most recent figures from the Department for Education (2020a) show that 38% of children in local authority care continuously for at least 12 months had scores that were cause for concern. A longitudinal study of children and young people aged 5-15 concluded that 72% had a mental or behavioural problem at the first point of entry into care (Sempik et al., 2008). Young people leaving care are five times more likely to attempt suicide than children living at home (Children and Young People's Health Outcomes Forum, 2012). Studies have identified predictors of mental health problems amongst the looked after population, including older age at being placed into care, and placement instability (Delfabbro & Barber, 2003; Tarren-Sweeney, 2008).

The emotional stability of children in local authority care may be compounded by multiple placement moves; exacerbating their risk of mental health problems, lowering their self-esteem and affecting their sense of identity (NICE/SCIE, 2010a; Schofield & Beek, 2005; Utting et al., 1997). A survey of 2,956 children in England found that 40% reported they had moved placements one to three times in the last two years, and 10% had moved four or more times (Children's Commissioner, 2017). Placement instability heightens difficulties with forming attachments to caregivers, hinders opportunities to make friendships, and changing professionals in their care

network means these relationships must be continuously rebuilt (Children's Commissioner, 2017; Stanley et al., 2005). Therefore placement instability may potentially contribute to subsequent placement breakdowns (Munro & Hardy, 2006), and is a key feature associated with outcomes for children in local authority care (Peacock et al., 2016).

1.1.1 The UK policy context for promoting the mental health of children in local authority care

UK child protection policy is governed by the Children Acts 1989 and 2004. Since the introduction of the Children Act, government policy for children in local authority care has centered on improving outcomes for these children, as well as providing placement stability (McAuley & Davis, 2009). In 2003, the publication of the policy document *Every Child Matters* included an aim of recognising the needs of vulnerable children and bridging the disparity in outcomes between children in local authority care and those in the general population (Department for Education & Skills, 2003). Following *Every Child Matters*, national statistics were published concerning children in local authority care, and onus placed on local authorities to promote better outcomes, for example in terms of educational achievement (McAuley & Davis, 2009; McAuley & Young, 2006). Despite some advances in publishing national data on these children's emotional wellbeing (e.g. Meltzer et al., 2003), arguably mental health has lagged behind other outcomes as a policy priority (Bazalgette et al., 2015). Tarren-Sweeney (2010) contends that governments across the globe have substantially understated the degree of change needed to produce better mental health outcomes for this group of children.

Since then, there has been increasing awareness amongst policy makers of the importance of mental health provision for children in local authority care. Statutory guidance by the Department for Education and Department of Health states that clinical commissioning groups and local authorities have a responsibility to recognise the greater mental health needs of these children, and to give equal importance to their mental and physical health needs (Department of Education & Department of Health, 2015; Department of Health, 2015). The Department of Health's *Future in Mind* guidance also highlights the importance of prioritizing the

mental health needs of vulnerable young people to ensure they engage with services (Department of Health, 2015). Achieving permanence and providing stability, in order to support emotional wellbeing, is included in the National Institute for Clinical Excellence (NICE) and Social Care Institute for Excellence's (SCIE) 2010 guidelines for looked after children and young people. Similarly, permanence, defined as a sense of belonging, identity and security (Care Inquiry, 2013; Schofield & Beek, 2005), was endorsed by the Care Inquiry in 2013, a collaboration of charities working within the field of children in local authority care and adoption (Care Inquiry, 2013). Research conducted by the NSPCC and Loughborough University in 2015 estimated that the cost of not providing support for children in local authority care's mental health needs as more expensive than investing in service provision (Bazalgette et al., 2015).

The recent policy focus on adequate mental health services for children in local authority care means there is mounting pressure for effective clinical interventions to be developed and evaluated (Ingleby-Cook & Dobel-Ober, 2013). Child and Adolescent Mental Health Services (CAMHS) are the National Health Service (NHS) run services for children in the UK. These operate on a tiered system, with more complex cases, such as those often presented by children in local authority care, needing the input of several different professionals in order to make changes (Tier 3) (Crockatt, 2009). Inpatient psychiatric treatment (Tier 4) can be recommended (McMillen et al., 2004), however current policy in the UK stresses the importance of providing mental health services in the least restrictive setting (Shepperd et al., 2009). Despite increasing recognition amongst policymakers of the importance of children in local authority care's mental health needs, there remain numerous challenges to delivering effective clinical interventions.

1.2 Challenges to meeting the mental health needs of children in local authority care

This section discusses the barriers to meeting the mental health needs of children in local authority care, including assessment, diagnosis, accessing appropriate services, shared working between agencies, and identifying evidence-based interventions. Gaps in the current knowledge and evidence-base will be identified, providing the rationale for the research undertaken in this thesis.

1.2.1 Challenges of assessment and diagnosis

Categorization into discrete psychiatric diagnoses can be problematic for children with traumatic histories who are experiencing mental health difficulties (DeJong, 2010). A trauma-based perspective helps to understand the complex symptoms and behaviours typically associated with these children, given the high prevalence of trauma and maltreatment amongst the looked after population. There is a wealth of research showing that traumatic experiences and maltreatment have a significant effect on numerous domains of functioning (Ford, 2005; van der Kolk, 2005). The term 'complex trauma' refers to children's experience of multiple, chronic traumatic events, usually of an interpersonal nature, and often occurring early in life by the child's caregivers (e.g. Cook et al., 2005; Finkelhor et al., 2009a; Ford, 2005). Effects of complex trauma, or of having caregivers who are not responsive to a child's needs, can cause dysregulation in many areas; defined as a breakdown in the system's normal ways of functioning (Dozier et al., 2006). These include neurobiological, physiological, emotional, behavioural, and cognitive functioning. Changes are often adaptive responses to the child's environment (Music, 2017; Stirling et al., 2008).

Experiences of trauma or maltreatment can lead to a range of diverse outcomes (Rutter et al., 2006), compounding difficulties of categorising such children into discrete diagnostic categories. Often no single psychiatric diagnosis accounts for all their symptoms (D'Andrea et al., 2012). These children can either be sub-threshold for a number of diagnoses, meaning they are unable to access mental health services (Luke et al., 2014), or they can be 'fit' into diagnostic categories that are not appropriate (DeJong, 2010; McCullough et al., 2014). Research by Tarren-Sweeney (2013a) in Australia found that 20% of a sample of children in local authority care (n=347) manifested complex trauma and attachment related difficulties that are not effectively captured within standard classification systems, namely the Diagnostic and Statistical Manual (DSM; American Psychiatric Association, 2013) and International Classification of Diseases (ICD; World Health Organisation, 2016) systems. Furthermore, a small study by McCullough et al. (2014) identified that although some foster children with histories of maltreatment were categorized as

being on the autistic spectrum, they showed evidence of good theory of mind; suggesting their difficulties may represent a response to trauma and a diagnosis of Autistic Spectrum Disorder was not appropriate. McCullough et al. (2014) argue that the current classification of Reactive Attachment Disorder within DSM-5 may not consistently capture the range of difficulties and experiences of children with traumatic histories. Van der Kolk (2005) also argued for the inclusion of a new category in DSM-5 – Developmental Trauma Disorder – which captured the developmental impact of childhood trauma, arguing that repeated experiences of trauma lead to predictable and pervasive consequences that were not encapsulated in the DSM-4 categories. However, the case for the inclusion of this category in DSM-5 was unsuccessful, and therefore children who have experienced complex trauma cannot be formally diagnosed with Developmental Trauma Disorder. Tarren-Sweeney's (2013a) research similarly supported the introduction of Developmental Trauma Disorder – or a related construct – into the ICD classification system, however the ICD-10 taxonomy does not currently recognise this either.

There is also evidence to suggest that measures of screening child mental health in the UK (including the SDQ; Goodman, 1997, and the Child Behaviour Checklist; Achenbach & Rescorla, 2001) are not adequate for assessing the complexities of problems experienced by these children (Tarren-Sweeney, 2013a). A study of 144 referrals to a specialist CAMHS team found that the single-report SDQ had low accuracy at identifying those in need of treatment when completed by young people or their carers (Wright et al., 2019). Tarren-Sweeney's (2007, 2013a) research focuses on developing new tools to more accurately measure the psychopathology of children in local authority care; the Assessment Checklist for Children (ACC) is a 120-item caregiver-report psychiatric rating scale, used across the UK, Australasia and North America. His findings suggest that the complexity of attachment-related difficulties shown by this group are more accurately conceptualized as profiles of attachment difficulties, rather than distinct types of attachment disorder. He argues that clinicians working with children with complex difficulties should adapt their clinical formulations, using a system profile approach rather than relying on standardized formulations of psychopathology. Furthermore, he proposes clinicians should use more comprehensive assessments than the typical mental health assessment focus on symptomology; broadening to include additional factors such as children's experiences and relationships. In the UK, a

recent tool has also been developed to help identify these children's needs across five domains of psychological functioning, including emotional wellbeing and indicators of psychiatric or neurodevelopmental conditions (the BERRI; Silver, n.d.). This suggests that, within the children in local authority care field, there is recognition of the difficulties with assessment, and researchers are developing new tools for screening and diagnosing mental health problems. Despite this, challenges remain in capturing the complexity of many of these children's presenting problems within standard psychiatric classification systems.

1.2.2 Challenges of accessing appropriate mental health services

Numerous researchers have highlighted the difficulties children in local authority care face in accessing mental health services (Bazalgette et al., 2015; Callaghan et al., 2004; McAuley & Davis, 2009; McAuley & Young, 2006; Tarren-Sweeney, 2010; Vostanis, 2010; York & Jones, 2017). A study by the NSPCC, comprising interviews with professionals and foster carers in four local authorities, found that all the local authorities had a range of services in place to support the mental health needs of children. However, there was a lack of defined processes for assessing their needs, and frequently children experienced barriers to accessing services, particularly those not in stable placements (Bazalgette et al., 2015). Another study, a survey of 113 foster carers, found that 49% of children with a mental health need were not receiving support from CAMHS (Bonfield et al., 2010).

Initial barriers can arise prior to referral to mental health services, from failing to identify the child's needs. The responsibility may often lie with foster carers to advocate on the child's behalf to access services, or even to recognise that they need support in the first place (Bazalgette et al., 2015). Furthermore, there is considerable variation in the extent to which the SDQ is used by local authorities across England (Bazalgette et al., 2015). As of March 2020, only 81% of children aged 5-16 years who had been in care for at least 12 months had an SDQ score (Department for Education, 2020a). These findings are in accordance with the House of Commons Education Committee's inquiry (House of Commons Education Committee, 2016), which concluded that current methods of assessing these children's mental health at the point of entry to care are inconsistent and often fail to

identify those needing support. Children with internalizing problems may be less likely identified than those with externalizing problems, meaning their needs are more likely to be overlooked (Bazalgette et al., 2015; Callaghan et al., 2004). Contrastingly, York and Jones (2017) interviewed 10 foster carers and found they did not experience problems gaining a referral to services; instead reporting difficulties accessing services once the child was within the mental health system. Across studies, barriers identified include high thresholds of CAMHS, failure to meet entry requirements, and long waiting lists (Bazalgette et al., 2015). Research conducted by the NSPCC found that, due to resource limitations, some CAMHS were only able to offer a service once children reached crisis-point (Bazalgette et al., 2015).

Additionally, children in local authority care are recognised as a mobile population; placement instability and multiple moves can result in delays to mental health service referrals, or delays from records being passed between local authorities (Bazalgette et al., 2015; Callaghan et al., 2004; McAuley & Young, 2006; Street & Davis, 2002; Vostanis, 2010). Some CAMH services may also refuse to accept children who are not in stable placements (Department for Education, 2020). Children placed out of borough appear particularly vulnerable for inability to access services, often due to logistical difficulties attending appointments (Bazalgette et al., 2015).

Even once a referral is accepted and treatment offered, there may be difficulties engaging some children and young people to attend sessions (Bazalgette et al., 2015; Callaghan et al., 2004; Vostanis, 2010). One study investigating looked after young people's views of mental health services found that perceived barriers to engagement included: fear of stigma (being perceived as 'mad'); long waiting times; logistical difficulties attending sessions and inconvenient appointment times; not liking their therapist; and having to attend a clinic rather than being offered home visits (Beck, 2006).

Given these challenges, it is arguable that these children's needs are often poorly matched to the services that generic CAMHS are designed to offer. Within UK child mental health services, there is a shift towards routinely offering time-limited, once weekly sessions (Bent-Hazelwood, 2020), however children with complex trauma related difficulties may require further support and continuity than generic CAMHS can provide (Tarren-Sweeney, 2010). In recent years, dedicated mental health services for children in local authority care have been introduced in the UK.

These are typically situated within statutory mental health or social care services, but can be managed by non-statutory agencies, depending on local area provision (Vostanis, 2010). The introduction of these services may reflect policy recognition of the differing needs of this population of children, as well as the need for effective multi-agency working surrounding children in local authority care (Golding, 2010; Kelly et al., 2003). However, there are undoubtedly several challenges to achieving effective working between agencies, which will now be discussed.

1.2.3 Challenges of multi-agency working around children in local authority care

Multi-agency working has been a core feature of UK policy within children's services for several decades (Salmon, 2004). Its importance has been particularly recognised for vulnerable children, including those looked after, with increasing awareness that often no agency can solely meet these children's needs (Biehal et al., 1995; Golding, 2010; Vostanis, 2010). Despite being a priority both at a policy and local level, in practice there are often many challenges for agencies to work together effectively (Golding, 2010). The consequences of unsuccessful joined-up working can be fatally serious, as concluded by the Laming inquiry following the death of Victoria Climbié (Laming, 2003). Despite recommendations for better communication between agencies, and many good examples of shared working, there are continuing instances of failure to collaborate effectively (Conway, 2009). More recently, the NSPCC study, investigating emotional wellbeing services for children in local authority care within four local authorities, found that approaches to shared working between social care, health, and education services were often fragmented (Bazalgette et al., 2015).

Children in local authority care often have very large networks of professionals surrounding them. As Conway (2009, p.24) notes, this means there are numerous professionals who must communicate effectively with each other, and it is common for 'fault lines' to appear between them. Problems that can be encountered in multi-agency working include different agendas and roles, differences in professional 'languages' and cultures, opposing targets, and disagreements over financial provision (Callaghan et al., 2004; Golding, 2010; Kelly et al., 2003). Street

and Davis (2002) outline several tensions that can occur when CAMHS and social services do not work collaboratively around children in local authority care. These include the perception from CAMHS that mental health support is best offered at times of stability, which may feel frustrating for social care. Furthermore, CAMHS professionals may feel that problems are being situated within the child themselves, when they perceive the problem to be in the wider system, among the network professionals.

Several approaches have been used to understand conflicts between agencies working in this field. The systemic approach situates problems as arising from relationships between people, rather than situated within the person (see Bingle & Middleton, 2019, for a discussion of systemic principles). The systemic concept of mirroring has been applied to multi-agency functioning, in terms of identifying 'patterns of interaction' in families that can become 'acted out' between agencies; for example, when working with children with traumatic histories, it may be that professionals identify themselves or others as the victim or persecutor (Granville & Langton, 2002, p.25). Although differing in its theoretical perspective, these concepts share some similarities with constructs used by another approach to understanding conflicts between agencies, namely the psychoanalytic approach (Granville & Langton, 2002). This perspective provides a framework for understanding unconscious dynamics that can occur within networks around emotionally disturbed children, leading to breakdowns in communication and trust, hindering professionals' thinking capacities, and subsequently impacting on the care they provide for the child (Conway, 2009; Emanuel, 2002; Granville & Langton, 2002; Hunter, 2001; Rocco-Briggs, 2008; Sprince, 2000). The literature on the psychoanalytic approach to working with professionals surrounding children in local authority care will be explored in further depth in Chapters 2 and 4. However, it is noteworthy that – without understanding of underlying dynamics occurring within networks, generated by the nature of the emotive working environment – there is a continued risk of breakdowns between agencies, despite shared working being a priority (Conway, 2009).

1.2.4 Challenges of identifying evidence-based mental health treatments for children in local authority care

Tarren-Sweeney (2010) outlines 10 principles for designing mental health services for children in local authority care. Recommendations include a specialised clinical workforce with expertise in working with these children, utilising conceptual frameworks for trauma and attachment related disorders; universal assessments on entry to care; sustained engagement and monitoring by services; integrated working between mental health and social services; and aligning services for children in foster care, those adopted from care, and children returning to their parents, to facilitate greater continuity of care.

Despite recommendations on service provision, currently the most effective clinical intervention for children in local authority care is unknown, with large gaps in the evidence base for what makes an effective mental health treatment for this population. The NICE/SCIE 2010 guidance noted that there are very few UK randomised controlled trials (RCTs) of sufficient quality to address the issue of which clinical interventions work for these children. There are also particular problems with conducting outcome studies of treatments for traumatised and maltreated children. Firstly, it may take several years to achieve clinically meaningful therapeutic change, meaning that any RCT would need to be long-term, including prolonged post-treatment follow-up (Tarren-Sweeney, 2013b). Secondly, the complexity of their symptoms and presentation makes it difficult for these children to be included in evidence-based guidelines, which are often based on discrete psychiatric diagnoses (Midgley & Kennedy, 2011). Outcome studies also often focus on those with homogenous conditions, which is unlikely amongst this population of children and young people. Furthermore, there exists a lack of validated measures to evaluate quality of life outcomes with these children (NICE/SCIE 2010a) and there are practical difficulties with accessing and retaining these children to research studies, for example gaining access from local authorities and social workers acting as informal gatekeepers (Hepstinall, 2000; Mezey et al., 2015). Tarren-Sweeney (2010, p.4) contends that researchers need to reformulate traditional ratings of treatment effectiveness for children with complex trauma and attachment related issues, with less focus on evidence hierarchies and instead using 'multiple evidence requirements'.

Luke et al. (2014) reviewed 106 studies of interventions targeting the mental health of children in local authority care, including interventions that work directly with the child (such as therapeutic interventions and mentoring programmes) and indirectly (for example, those targeting foster carers). They concluded that the limitations of current research make it very difficult to identify beneficial interventions, namely because of lack of randomisation, overreliance on caregiver reporting, and insufficient follow-up within studies. Of those interventions included in the review, the majority were based on attachment theory or social learning theory, although other approaches including cognitive-behavioural therapy and psychodynamic therapy were also included. The available evidence suggests that interventions should focus on building secure and trusting relationships, rather than only on reducing problems behaviours. Furthermore, the review concluded that services are more beneficial when targeting the network around the child as well as the child themselves, including training and support for foster carers, social workers, and other professionals. Not one intervention is likely to address this entire population of children's problems. Finally, the reviewers suggested that interventions should have a clear theoretical base, and that for children with particularly complex problems, attachment or social learning theory based interventions may not be sufficient to address the depths of their issues. They instead suggested that psychotherapeutic approaches, focusing on the child's internal world, may be more appropriate.

The Luke et al. (2014) review also identified several gaps in the current literature, proposed as necessities for future research. These included: the need to investigate the mechanisms by which interventions cause change; exploration of interventions targeting children's emotional issues rather than purely behavioural issues; and the need for interventions for children with complex needs. They noted that despite widespread recognition of the complexity of problems amongst this population, many interventions were time-limited or focused on one aspect of the child's presenting problems.

1.2.5 Psychoanalytic ways of working with children in local authority care

Given the complex needs of this highly vulnerable population, and the challenges described in the sections above, there is a pressing need for further research into

mental health treatment approaches, including alternatives to inpatient care. While the children in local authority care mental health field is an area lacking a well-established evidence-base, one approach that has traditionally played a role in both services and therapy for these children is psychoanalytic work. Psychoanalytic psychotherapy has been used in mental health services in the UK, Europe and North America for many years and psychoanalytic child psychotherapy (henceforth referred to as 'child psychotherapy') is recognised as a 'core profession' by the NHS in the UK.

Psychoanalytic child psychotherapists provide a variety of services, including individual therapy with children and young people, therapy in a family context, consultation, supervision, teaching and training to other professionals (Midgley et al., 2009; Sherwin-White et al., 2003). The psychoanalytic approach has historically lacked a clear evidence-base for use with children and young people in comparison to other treatment approaches, although in recent years, there is growing evidence of its effectiveness (Midgley et al., 2017). Despite this, the use of – and effectiveness – of psychoanalytic ways of working with children in local authority care is poorly understood, and historically there are debates around whether it is an effective treatment for children who experienced trauma. Given the need to establish effective mental health interventions for these children, exploring the psychoanalytic approach to working with them is a worthy avenue of research. This is particularly pertinent given calls from the Luke et al. (2014) review for interventions that target children's emotional issues, and those with potential suitability for children with complex needs, for which other approaches may be insufficient.

1.3 Research design and structure of this thesis

The overall aim of this thesis is to explore psychoanalytic ways of working with children in local authority care, including understanding the role of child psychotherapists working in this field. The research initially began with an exploratory study to determine the nature and provision of child psychotherapy with children in local authority care in the UK. Thereafter, it had an emergent design, in which each study's findings were used to inform the aims and design of the next study. The empirical component of this thesis comprises three studies.

Chapter 2 reviews the literature concerning psychoanalytic ways of working with children in local authority care, including the potential suitability and challenges of this approach.

Chapter 3 presents the findings of study 1. Study 1 aimed to identify current psychoanalytic models of working with looked after and adopted children amongst UK child psychotherapists. The study also explored child psychotherapists' perceptions about therapeutic work with these children and their professional network, and their perceptions about the contribution that child psychotherapy can make to work in this field.

Chapter 4 presents the findings of study 2. Study 2 aimed to gain an in-depth understanding of the ways in which child psychotherapists worked with the professional network around children in local authority care, including social care, education, health, and foster carers. In particular, the study aimed to explore how child psychotherapists understood and experienced their work with the network, and what they saw as particular to the psychoanalytic approach.

Chapter 5 presents the findings of study 3. Study 3 was an ethnographic case study of child psychotherapists within a specialist CAMHS team, based within a social care setting. The study aimed to examine how the psychoanalytic child psychotherapists functioned within a multi-disciplinary CAMHS team, in a children's social care setting.

Chapter 6 is a general discussion of the findings from all three empirical studies, as well as a discussion of limitations, and research and practice implications.

1.4 A personal reflection on the research process

When I started this PhD, it was a funded studentship with the broad topic of exploring psychoanalytic therapy for children in local authority care with histories of trauma or maltreatment. My background is in psychology and, prior to undertaking the thesis, I had only a limited knowledge of child psychotherapy as a profession, and psychoanalytic theories. Prior to commencing the PhD, I had worked for several

years as an administrator in a children's social services department. This role sparked an interest in working with, and studying, children in local authority care, and I subsequently worked in both academic and clinical settings as a researcher with children in local authority care and their families, researching interventions targeting their physical or mental health. One of these roles was in a therapeutic community for children on the edge of care and their families, using mentalization-based treatment (MBT; Bateman & Fonagy, 2006) to improve the parents' capacity to mentalize about others' mental states, including their children's. Although MBT is an integrative treatment approach, combining ideas from several fields including psychoanalysis, this role gave me some understanding of how psychoanalytic ideas could be used to work with these children and their families. I was therefore excited to begin work on a PhD that combined studying these children's mental health with a treatment approach that I had recently gained a little knowledge of. Through undertaking this doctorate, I feel I have been on a journey of learning about psychoanalytic theories generally, and psychoanalytic perspectives on these children. During the early stages of this journey I found some of the theoretical concepts quite difficult to grasp and had to devote a significant amount of time to understanding relevant theories. Over time my appreciation of psychoanalytic ways of working has piqued, particularly in relation to children with experiences of trauma.

At the outset of this funded PhD, the intention was to conduct an audit of the child psychotherapy profession about their work with children in local authority care, and subsequently collaborate with a specialist service to pilot a manualised psychotherapy treatment for these children, examining key issues related to the feasibility of developing a future clinical trial. In practice, study 1's survey of the profession highlighted the emphasis that child psychotherapists placed on their work with the professional network around the child, and foster carers, and I decided to pursue this aspect of practice in further studies. The findings of the initial study therefore changed the course and focus of the PhD research.

This change required me to choose different methodologies than originally intended, as qualitative methods were most appropriate for the research questions developed in studies 2 and 3. Prior to commencing the PhD, my background was principally in quantitative research, although I had gained a little experience in qualitative methods, through conducting interview and focus group studies. I particularly found that using ethnography as study 3's research method broadened

my conceptual and experiential knowledge of a method which, coming from a psychology background, had previously been relatively unknown to me. Ethnography's focus on participant observation, on building sustained relationships with the people in the culture under study, and of embracing the researchers' critical reflexivity, were all new skills to me on commencing the study, which I initially felt cautious and apprehensive about. However, I very much enjoyed the data collection process, and found it a positive, enlightening, and privileged experience to observe two child psychotherapists' work 'up close'. Since undertaking this PhD, I have come to value the use of this method as a means of gaining rich, in-depth understanding of a culture or phenomenon, which other qualitative methods may not capture so readily. I particularly support its diversification from traditional anthropology into fields including healthcare research (see Vindrola-Padros & Vindrola-Padros, 2018) and psychological therapies (e.g. McLeod, 2011; Siddique, 2011), for which there is an emerging literature.

Undertaking this PhD also demonstrated to me the complexities of conducting research within both an NHS and social care setting, particularly gaining access to participants and managing the priorities of different agencies and governing bodies. For example, in study 3, the local authority did not give permission for foster carers to be interviewed or observed, meaning I had to alter the scope of the study to focusing solely on the child psychotherapists' work with the professional network around the child. Managing the ethical process for three governing bodies (UCL, the NHS, and the local authority), at times I found frustrating and challenging, and I think at the outset I was fairly naïve to the level of detail and re-drafting required for approval to be granted. Despite this, through undertaking this process I learnt many practical strategies to overcoming ethical challenges and being able to move on to data collection rekindled my enthusiasm for the research.

The qualitative data collection in studies 2 and 3 was, for me, the highlight of the research process, and I very much enjoyed listening to child psychotherapists' accounts of, and observing, their work with the networks around these children. Undertaking a studentship part-funded by the regulatory body for UK child psychotherapists, and so closely observing child psychotherapists' practice in study 3, at times produced a tension for me personally in terms of maintaining neutrality as a researcher. I often felt as if I wanted to do their work 'justice' by highlighting what I perceived was a really important contribution to working with these vulnerable

children, particularly after having shadowed two child psychotherapists' work for several months in study 3. I felt a level of responsibility in ensuring that my analysis centred on participants' perspectives and voices – and I sometimes found it challenging to give credence to my own interpretations and perspective. This was particularly so in study 3, where most data collection was through my own observation of participants, and at times I found it difficult to balance my observations with what participants were telling me through interviewing. Supervision with my PhD supervisor was critical in allowing me to develop an awareness of these feelings, and to remind myself that my role through undertaking this research was to understand the place of child psychotherapy in working with children in local authority care, not to 'make a case' for it. I also found supervision helpful in respect of developing and recognising my own agency and voice in the research process – something my supervisor pushed me repeatedly on and which I think that using ethnography as a method was particularly useful for.

1.5 Conclusion

This chapter has highlighted the multi-faceted vulnerabilities of children in local authority care, including increased risk of mental health problems compared to children living with birth families. Despite this, these children often face many challenges in accessing appropriate mental health services, and currently the most effective clinical intervention remains unknown. This chapter has suggested that exploring the psychoanalytic approach to working with children with complex trauma is a worthy avenue of research. The following chapter will review the literature concerning the psychoanalytic approach to working with children with histories of trauma or maltreatment, and specifically with children in local authority care.

2 Literature review: Psychoanalytic ways of working with children in local authority care

2.1 Introduction

In the first half of the twentieth century, psychoanalytic treatment with children was originally developed for those with 'neurotic' problems, and it was unclear whether these ways of working were appropriate for children with early histories of trauma or maltreatment. However, from the 1950s onwards, as psychoanalytic child therapy took up a place in general Child Guidance Clinics in the UK, therapists were increasingly challenged to work with children with histories of trauma, maltreatment and neglect, and had to find ways to modify their technique to ensure it was suitable (Rosenfeld & Sprince, 1963, 1965). Nowadays, child psychotherapy is used in routine clinical practice with children with traumatic histories, including those in the care system. Despite this, the use and effectiveness of psychoanalytic work with children in local authority care is poorly understood.

This chapter reviews the existing literature on psychoanalytic child psychotherapy with children in local authority care, to contextualise the research questions identified in this thesis. The chapter begins with an overview of child psychotherapy as a profession in the UK, before moving on to discussing psychoanalytic perspectives on working with children in local authority care. The chapter centres around four key questions: what is the conceptual logic for using the psychoanalytic approach to working with children in local authority care? What are the challenges to working psychoanalytically with these children? What is known about the format and content of this work, both inside and outside the therapy room? What does the evidence indicate about the effectiveness of psychodynamic therapy for children with experiences of trauma or maltreatment? Exploring these questions is pertinent to understanding the potential of this approach as a way of working with children in local authority care; what is known about current clinical practice; and areas lacking research evidence that require further exploration.

2.2 Child psychotherapy as a profession: definition and traditions

In many countries, psychoanalytic work is a specialist post-qualification training for professionals with a background in clinical psychology, psychiatry or social work. In the UK, child psychotherapy is regarded as a 'core profession' in the NHS, offering mental health treatment for children and adolescents suffering from behavioural, emotional or social difficulties (Midgley et al., 2009). This literature review will primarily focus on the UK traditions of child psychotherapy, as the research undertaken in this thesis is of child psychotherapy in a UK context.

As a treatment approach, child psychotherapy has its roots in psychoanalytic theory¹ (Likierman & Urban, 2009). In distinguishing the fundamental aspects of this approach, the relationship between the child and therapist, known as the transference relationship, is considered the central mechanism of change (Barrows, 1996). Transference occurs when the child's internal world, populated from their previous infantile experiences, unconsciously compels them to redirect feelings onto the therapist and repeat patterns from old relationships (Barrows, 1996). For child psychotherapists, play is considered an important tool by which children express their conscious and unconscious thoughts, wishes and fantasies, which are also expressed through their verbal and non-verbal communications and behaviour. Child psychotherapists also pay close attention to the feelings these communications elicit in themselves, known as countertransference. Combined, these allow the therapist to develop an understanding of the child's internal world. The therapeutic setting is also vitally important, with the provision of regular, predictable sessions for the child, in the same room, and with their own toys. It is hoped through this that the child will develop a sense of a consistent adult presence, who they can eventually begin to build a trusting relationship with (Midgley et al., 2009). Within this context, broadly speaking the therapeutic intervention is the child psychotherapists' interpretations of

¹ Whilst the term 'child psychotherapy' can be used broadly to describe a variety of psychotherapeutic approaches to working with children and young people, in this thesis, the term refers specifically to psychoanalytically trained therapists. Whilst sometimes referred to as 'psychoanalytic child and adolescent psychotherapists', this thesis will use the shortened name of 'child psychotherapists'.

what is happening in the room, the transference relationship, and the child's internal world. Over time, it is hoped that this process will enable the child to put feelings into words and internalise and develop more positive ways of forming relationships with others (Association of Child Psychotherapists, 2011; Barrows, 1996).

Although these are the basic tenets underpinning child psychotherapy, differing theoretical psychoanalytic orientations over the last century have resulted in variations to treatment approaches (Likierman & Urban, 2009). Consequently, in modern child psychotherapy there remain distinct schools of thought, including traditions based on the two well-known pioneers of child psychoanalysis, Anna Freud and Melanie Klein. Additionally, there is an Independent group of object-relations theorists, which grew out of Klein's mode of thinking and included theorists such as Donald Winnicott and Ronald Fairbairn, as well as a Jungian based approach (Midgley et al., 2009). Despite this, there are enough commonalities amongst the approaches to agree on training requirements for child psychotherapy training centres in the UK (Lanyado & Horne, 2009), as well as ways of working with children and adolescents (Midgley et al., 2009). All UK registered child psychotherapists have completed a child mental health based training accredited by the Association of Child Psychotherapists (ACP) which lasts for at least four years. There are currently five training schools in the UK, with the largest being the Tavistock and Portman NHS Foundation Trust in London, based on a Kleinian tradition.

2.3 What is the conceptual logic for using the psychoanalytic approach to working with children in local authority care?

In the first half of the twentieth century, psychoanalytic work with severely deprived children was not recommended; as a treatment principally designed for those with 'neurotic' problems, the appropriateness of it for children with early experiences of trauma or maltreatment was unclear. Such children were viewed as too 'emotionally damaged' to make use of psychoanalytic therapy, and there were also perceived to be many practical difficulties that may arise (Boston & Szur, 1983, p. xiii). While psychoanalytic understanding of the impact of trauma goes back at least to Ferenczi in the 1920s (Dupont, 1985; Ferenczi, 1933), and arguably even earlier to Freud in the 1890s (1894, 1896), traumatised children were previously not considered to have the ego strength necessary for psychoanalytic psychotherapy. The 'provision of

primary experience' was viewed as more suitable for traumatised children (Barrows, 1996). This approach is described by Dockar-Drysdale (1966), based on Winnicott's ideas of the initial state of unity between the mother and newborn baby, with the mother providing the impression they are a part of each other. According to this approach, children suffering from deprivation face an interruption in the normal process of progressively separating from the mother, meaning they are unable to develop a sense of integration of their own personality. Within this therapeutic context, traditionally used in residential settings, the therapist provides the primary experience that has been lacking from the deprived child's life, until the child is able to establish their own ego (Dockar-Drysdale, 1966).

Despite historical perceptions that psychoanalytic therapy was not an appropriate method for traumatised children, there is evidence that many children in psychotherapy from at least the 1940s arguably had disturbances of ego functions (see Rosenfeld and Sprince's (1963) description of work with 'borderline' children, distinguishing them from children with neurotic or psychotic conditions). Within the Anna Freudian tradition, in the 1950s there was recognition of a broader range of individuals for whom psychoanalytic therapy was appropriate, including individuals who – despite ego disturbances – had the capacity for self-reflection during the transference relationship (known as the 'widening scope of indications for psychoanalysis'; Freud, 1954; Stone, 1954). As psychoanalytic child therapy took up a place in general Child Guidance Clinics in the UK, therapists were increasingly challenged to work with children with histories of trauma or failures in early ego development; there was however seen to be a need for adapting technique to better meet their needs (Rosenfeld & Sprince, 1965). One of the first attempts at a systematic description and evaluation of work being done in this area within the Kleinian tradition was Boston and Szur's (1983) book, *Psychotherapy with severely deprived children*, which was based on the Tavistock's workshop of psychotherapy with 80 children in local authority care. Through undertaking this work, Boston and Szur (1983, p.3) concluded that 'although not easily reversible, the damaging effects of early deprivation might be alleviated by appropriate therapy', eventually leading to the Tavistock providing psychotherapy to more children in local authority care. Boston and Szur (1983) found there to be some common themes amongst these children that typically appear during therapy. The clinical literature since then indicates that child psychotherapists are increasingly providing individual therapy for

children in local authority care (see, for example, Briggs, 2015; Hunter, 2001; Kenrick et al., 2006; Lanyado, 2003).

In the UK, the psychoanalytic tradition to thinking about the effects of trauma on children has broadened to incorporate research from other fields, including attachment theory and neuroscience research. Several UK psychoanalytic child psychotherapists have written about synthesising these fields, for example Music's (2010, 2019) approach to understanding children's emotional development integrates ideas from neuroscience, attachment theory, mindfulness, and developmental psychology. Both Music (2019) and Emanuel (1996) have linked neuroscience research with psychoanalytic thinking. This integration of ideas from diverse fields is reflected in the work of many contemporary child psychotherapists, despite being trained in different theoretical approaches (see Aronson, 2020 for a discussion); however, few empirical studies have examined the degree to which child psychotherapists integrate different perspectives in their ongoing practice.

As the clinical literature indicates that children with traumatic histories – including those in the care system – are nowadays seen in individual therapy, there is a need to understand the potential contribution the psychoanalytic approach offers for this group of children, including mechanisms of change. This provides the foundations for research into its use with children in local authority care, which is the starting point of the research undertaken in this thesis. The following sections discuss potential ways whereby the psychoanalytic approach may affect change in children in local authority care. These include providing a sense of continuity and tackling issues of loss, mourning and abandonment; modifying maladaptive defences; the provision of containment; and breaking cycles of repetition. The vast majority of the literature is in the form of either theoretical papers or child psychotherapists' individual case studies; the strengths and limitations of which will be discussed at the end of the section.

2.3.1 Providing a sense of continuity and tackling issues of loss, mourning and abandonment

Hunter-Smallbone (2009) contemplates that tackling issues of loss and abandonment is fundamental to psychotherapy with children in local authority care.

These are children who have experienced significant upheaval, with removal from their birth families often followed by repeated placement moves, and discontinuity from professionals in their care network. Feelings of loss may be exacerbated for children who have repeatedly moved in and out of care, experiencing recurrent loss and separation and differing caregiving environments. Kenrick (2000) writes about loss for children in transition, feeling that repeated placement moves cumulatively harm the child further by not allowing them a sense of continuity of experience. Hunter-Smallbone (2009) reflects on the emotions that these separations may arouse, which are much more complex than simple mourning for the absence of their parents. Losing a sense of belonging to their birth family may engender profound feelings of worthlessness and guilt, with some children feeling that they are to blame for the loss and worthy of this perceived punishment. Simultaneously they may harbour significant feelings of hostility and anger towards their parents for deserting them. Rustin (2006) states that a sense of belonging is one of the core building-blocks of our sense of identity; this basic understanding of 'who we belong to' is disrupted for children taken into care. Evans (2020) discusses how these children's fear of further loss can prevent them from experiencing love within relationships, meaning love can become a taboo.

A recurrent theme from the psychoanalytic literature when describing these children's play, is of falling, not being held, being dropped or discarded (Boston & Szur, 1983; Edwards, 2000; Hunter, 2001; Lanyado, 2003). This may involve the child throwing themselves from furniture with little care for their own safety, or of characters in their play being dumped, disposed of, or thrown in the bin (Edwards, 2000; Hunter, 2001). Edwards (2000) describes this as reflecting these children's experiences of being emotionally dropped themselves. This material indicates the potential distinctiveness of the psychoanalytic approach, in attempting to understand the child's feelings and communications that may underlie their behaviour and presentation in therapy sessions; however the literature does not indicate child psychotherapists' perceptions about the uniqueness of the psychoanalytic approach in comparison to other treatment methods with these children.

In contrast to descriptions of loss being displayed so overtly through behaviour, other child psychotherapists have drawn attention to children whose behaviour presents as markedly different. Boswell and Cudmore (2017) describe children who present as 'unaffected' by their loss or described as 'resilient' by adults,

feeling that their outward presentation is masking their internal distress. They conducted a small interview study of foster carers, adopters and social workers of five children transitioning to adoption, finding there was often a sense of relief amongst professionals when children transitioned 'smoothly' or did not demonstrate any emotion towards the move. Their analysis concluded that the adults found it very difficult to fully engage with the child's emotional state at this time, particularly the feelings of loss likely engendered from severing their relationship with the foster carer. This empirical research – with a systematic approach to analysis – is rare amongst the vast majority of descriptive case studies making up the literature regarding psychoanalytic ways of working with children in local authority care. However, the study is limited by its small sample size and that the child psychotherapists were 'insiders' to the research, interviewing professionals who they worked alongside in their place of work.

While some child psychotherapists have spoken about approaching issues of loss and abandonment within the transference relationship, others suggest that treatment allows the child to not only develop a transference relationship, but also to use the therapist as a new developmental object (Hurry, 1998). Within Hurry's (1998) book *Psychoanalysis and Developmental Therapy*, Green (1998) describes therapy with a boy who experienced an early traumatic loss, arguing that treatment allowed him to experience the mourning process, eventually recognising his own emotions in relation to this loss. Therefore, the therapist is perceived as serving a developmental function in relation to tackling issues of loss amongst deprived children.

It has also been noted that the therapist can provide the continuity that has been missing previously from the lives of many of these children. Canham (1999) proposes that the provision of regular therapy sessions allows these children to develop the concept of time, giving a sense of rhythm to their lives. Hunter-Smallbone (2009) states that child psychotherapists can provide the stability needed during times of transitions in care. Separation from the therapist may be particularly difficult, for example during holiday breaks, and there may be an escalation in their presenting problems at those times (Boston & Szur, 1983; Canham, 1999; Hunter, 2001; Jackson, 2004). This may tap into their feelings of abandonment (Canham, 1999) and increase anxiety that the therapist will not return. However, these breaks can also have a positive impact. Canham (1999) argues that they firstly allow the therapist to explore the feelings aroused by the separations within the transference

relationship, and eventually reflect on feelings associated with previous losses. Canham (1999) further comments that the child witnessing that their therapist does return helps to slowly cement the introjection of a good internal object in their mind. A sense of continuity with an appropriate adult figure is relevant given the often large, unwieldy, and potentially fragmented professional networks surrounding these children (as discussed in Chapter 1) and suggests a potential mechanism by which the therapeutic relationship may affect change.

2.3.2 Modifying maladaptive defences

Defence mechanisms are a central tenet of the psychoanalytic approach and provide a framework for understanding how children with experiences of trauma or maltreatment may unconsciously manage emotions. Defence mechanisms are coping strategies used unconsciously to protect the self from overwhelming experiences and feelings of anxiety (Freud, 1894, 1896). Clinical material of child psychotherapists' individual case studies suggests a variety of ways in which children with experiences of trauma may protect their mind. Children may display several strategies for protecting themselves against psychological pain, therefore defences can be thought of as different aspects of how the mind protects itself. Within Freud's (1923) theory of personality, tensions between the id and superego create the emergence of anxiety; in response to this conflict, the ego develops various strategies to mitigate the unacceptable feelings. Defence mechanisms are a normal part of a child's psychological development, and can be healthy, adaptive responses to coping with psychological pain. However, they can become maladaptive when their use results in behaviour that negatively impacts on a child's mental health. The psychoanalytic perspective offers an understanding of how trauma may affect a child's development and use of defences. Persistent traumatic experiences can engender extreme negative feelings that challenge children's developing strategies for modulating emotions, causing the child to develop new mechanisms for regulating their affective responses (Parens, 1991). These defences can initially be adaptive responses to a traumatic situation (e.g. the 'fight-or-flight' response), but there is a cost to their persistent use, which can result in maladaptive behaviour and psychopathology.

Within the clinical literature, numerous child psychotherapists have described their perception that by the time of presentation to a child psychotherapist, maladaptive defences may be particularly entrenched for children in local authority care because of the levels of trauma and maltreatment they have experienced (e.g. Hunter, 2001; Kenrick, 2000). Henry (1974) used the term 'doubly deprived' to refer to the defences used by many of these children: the first source of deprivation is external and beyond the child's control, stemming from the trauma or maltreatment experienced, and the second is from internal sources as the child develops defences blocking them from accessing support from foster carers or professionals in their care network. Boston (1983) states that the core of the double deprivation is the child's identification with a rejecting parent; subsequently they are inclined to perceive other people as similar figures.

Among these defence mechanisms is projection, defined in Freud's (1894; 1896) classical theory as the unconscious displacement of unwanted or threatening emotions onto another person, usually to get rid of them. Hughes (1999) states that projections by children in local authority care are often of hopelessness and hatred, stemming from an entrenched belief that humans are inherently cruel and punishing. Kenrick (2000) and Hunter (2001) describe the often chaotic nature of some children in therapy who persistently evacuate their emotions or direct abuse towards the therapist like a 'whirlwind' (Kenrick, 2000, p. 398); projecting their emotions out because they cannot process or make sense of them. A particularly forceful type of projection described by Klein (1946) is projective identification, which Klein viewed as serving a principally evacuative purpose, and is firstly used by the infant to communicate primitive states of mind. Kenrick (2006, p.26) states that when children are using projective identification in therapy, it can feel as if they are 'trying to force (themselves) intrusively into the mind and body of the therapist.' These behaviours can also leave foster carers feeling rage or sadness at the child's behaviour; Kenrick (2006) states that it is important at those times for the foster carer to pause and understand that some of their own feelings may originate from the child's projections, to avoid them responding reactively. In contrast, Music (2009) discusses the presentation of some neglected children who do not project into others, meaning they are often overlooked by professionals because they present as emotionally numb.

Splitting behaviour can also occur, in which the child does not unite positive and negative aspects of the self and others. Boston and Szur (1983) and Kenrick (2006) suggest that this could take the form of an idealisation of the child's birth parents, whilst projecting the negative image of the parents onto the therapist or foster carers. The child may also split off parts of their self, such as aspects of the trauma experienced, or their need for dependency, so that they can instead feel like a powerful, independent figure (Henry, 1974; Hindle, 2000). Kenrick (2006) writes that it can be very difficult for a therapist or foster carer to challenge the child's splitting behaviour as it may be too intolerable for them to think about their parents' abusive behaviour, and the feelings of despair this engenders. This clinical material suggests the need for robust support around foster carers, however, the literature on working with foster carers to manage feelings aroused by the child's defensive behaviours is sparse.

The theme of anger and aggression has been consistently described as emerging within children's play. Strati (2007) describes a child's obsession with strong, emotionless robots, encased within a protective shield, while Marsoni (2006) depicts a child's violent and destructive attacks on toys. Anna Freud's (1936) concept of identification with the aggressor (originally introduced by Ferenczi, 1933) has been applied by child psychotherapists working with these children; this allows the child a means of psychic survival by maintaining a positive view of an abusing parent on whom they are completely dependent. Children who are identifying with an aggressive parental figure may present as cruel and destructive themselves, lessening their feelings of helplessness by believing they are an omnipotent figure (Hughes, 1999; Rustin, 2001). Hopkins (2006) takes a different perspective and draws on attachment theory; viewing this defensive need to be controlling and self-sufficient as rooted in a disorganised attachment pattern (Main & Hesse, 1990). Hopkins views the defence as the 'solution' to the paradoxical 'fright without solution' in which the child faces conflicting emotions to both approach and flee an abusive parent.

Collectively, there appears to be a rich clinical account of the mechanisms of defence and how they may play out for children in local authority care. The literature has largely focused on these children's presentation in therapy sessions and an understanding of their internal worlds. There is emphasis amongst many child psychotherapists of the use of gradual interpretations, eventually allowing these

children to feel safe enough to no longer rely on more maladaptive defences (Hunter, 2001; Rustin, 2001; Strati, 2007). Instead the hope is for them to develop healthier, more adaptive defences, including the capacity to tolerate unpleasant emotions. Conversely, there are debates amongst child psychotherapists in the field about whether interpretation of defences is over-emphasised in work with deprived children. Music (2009) argues that, while one role of the child psychotherapist is to help children in managing painful emotions, another is to facilitate a sense of pleasure in them, particularly using play within the therapeutic relationship as a means of nurturing developmental growth. Drawing on neuroscience research – that the appetitive system of the brain needs enjoyable interactions to grow – he argues that psychoanalysis has largely neglected encouraging the positive and instead focused on working with the negative.

Furthermore, while some traditions emphasise interpretation as needed to modify maladaptive defences, other child psychotherapists have recognised the need to respect the child's defences and approach them with great care. Newbolt (1971), in describing a case of psychotherapy with a child in foster care, felt that the child actually *needed* her defences at the beginning of therapy and during transitional periods in care, meaning that interpretations at these stages would be inappropriate. Kenrick (2000, p.406) similarly describes a child who 'sets out, needing his defences, carrying, like the turtle, his house on his back'. This poses the question of whether therapy is indeed appropriate at certain timepoints in these children's lives – when there is a need for the child to hold on to their defences – and if it is appropriate, how therapists are approaching the relationship at these times.

2.3.3 Provision of containment

Bion's (1962) theory of the development of thinking provides a model for understanding some issues that may present in psychotherapy with children with experiences of trauma or maltreatment. His notion of containment, borne out from Klein's (1946) concept of projective identification, is particularly relevant. In ordinary caregiver-infant relationships, when the infant is too young to make sense of his feelings and experiences, he projects them into his mother or caregiver through his cries. The mother holds and contains the infant's anxieties, processing them in a way

that Bion terms maternal reverie. The mother then returns the infant's feelings in a more bearable form, for example feeding him, or picking him up and soothing him. This practice of containing, processing, and responding to the infant's feelings Bion terms the alpha function. It provides the infant with an experience of the mother's mind and her ability to have thoughts; with repeated experiences of this, the infant is eventually able to process their emotional experiences themselves. However, for many children in local authority care, lack of containment gives rise to overwhelming and unprocessed emotions which Bion calls beta elements, for example when an infant's cries are not responded to. Beta elements cannot be stored or processed and will only be evacuated. Kenrick (2000) states that children in local authority care may have had little sense of a containing adult presence in their lives, who is able to understand and contain their experiences. Over time, failure to build up the internal capabilities necessary for thinking means that these children may develop defences against thinking.

In his paper *Attacks on linking* (Bion, 1959), Bion describes a form of defence mechanism against thinking, namely the destructive attacks that some psychotic patients make in linking together objects in their mind. Henry (1974) applies this same concept to children in local authority care, by describing the way these children may make attacks on links within their own mind, also attacking the link between their own and the therapist's mind. This may be a way of protecting themselves from feelings of vulnerability and dependency, which are too painful to bear, meaning they have to 'execute' the feelings very quickly (Henry, 1974, p.23). Music (2009) applies Alvarez's (1992, p. 143) description of psychotherapy with autistic children to children who have experienced severe neglect, arguing that they often display quite 'cut-off' behaviour, terming them 'undrawn' children (Alvarez & Reid, 1999). Music (2009) argues that these children might not be attacking links in their mind, but that their links have failed to develop properly. Similarly, Emanuel (1996), discussing babies born addicted to heroin, argues that when trauma occurs in very early infancy, there are no mental structures in place to protect against the effects of the trauma, leading to a cumulative impact of the trauma in which these structures then do not develop properly.

Bion's theory of the development of thinking has been used widely within the clinical literature to describe the function of the therapist when working with children in local authority care. Many child psychotherapists have reflected that they can act

as a containing presence for these children, being able to hold their fears and anxieties and endure the projections put into them (Henry, 1974; Lanyado, 2017; Marsoni, 2006). In this way, Marsoni (2006) likens the therapist to performing the alpha function for the child that their primary caregiver was unable to. The difficulties of offering containment in this work appear immense. In her paper, *The therapist with her back against the wall*, Rustin (2001, p.274) likens her role of experiencing two children's psychic pain to a process of 'survival'. Whilst the children's presentation in sessions was very different, sustaining the therapy was equally difficult; she describes having to withstand the virulent attacks of one child, while enduring her feelings of futility, boredom and irritation with an extremely passive, emotionally numb child. Music (2009, p. 144) similarly states that for children who appear very cut-off and deadened, 'the clinical challenge is to stay psychologically alive and hopeful enough to be able to breathe life back into them.' Rustin (2001) concludes that traumatised children needs to have the therapist survive the unbearable, before they can even begin to think about creating an environment for change. Through acting as this container for the child's projections and remaining a consistent presence in their life, gradually it is hoped that the child can build up their capacity to think and reflect on their emotions. Despite this, there are debates amongst child psychotherapists about the extent to which traumatised children can achieve insight into their difficulties (Gibbs, 2006). Several therapists have noted their feelings that for some of the most deprived children, they lack the mental apparatus necessary for thinking; Marsoni (2006) wonders how they can begin to process the trauma experienced when they lack the capacity to have thoughts. Furthermore, while the clinical literature has heavily focused on the function of the therapist in acting as a container for the child's feelings, and indicated the technical difficulties of providing containment, there is a lack of understanding about how child psychotherapists manage the feelings aroused in this work.

2.3.4 Breaking cycles of repetition

Another potential means by which the psychoanalytic approach may affect change is through breaking cycles of repetitive behaviour. Freud introduced the concept of repetition compulsion, stating that 'a thing which has not been understood inevitably

reappears; like an unbidden ghost it cannot rest until the mystery has been solved and the spell broken' (Freud, 1909, p. 122). It refers to the repeated re-enactment of a traumatic situation, which is not consciously remembered, but unconsciously and compulsively reappears. In the case of children in local authority care, several child psychotherapists have noted that the repetition compulsion can be seen within their play and their relationships with others (Hopkins, 1986; Marsoni, 2006). Marsoni (2006) describes the repeated acting out of a child's violent play with dolls, which could only ever be evacuated and never reflected upon. Hopkins (1986) discusses Freud's assertion that this repetition in play represents the child's way of grasping anxiety felt as a result of their deprivation, while Jackson (2004) similarly perceives that repeating an incident is the child's attempt to control and master it. The repetition compulsion can also be viewed as an example of the double deprivation described by Henry (1974); a cycle of rejection occurring when the child pushes away their external sources of support, thus confirming their view of them as rejecting, and thereby preventing them from forming new and positive future relationships (Robson, 2014). A potential consequence of this cycle of repetition could be the foster placement breaking down, because the foster parents feel overwhelmed and unable to deal with the rejection of their support. This again highlights the difficult role of foster carers, and the need for support around them to manage feelings aroused in the relationship with the child in their care.

Some child psychotherapists have argued that therapy can help children to overcome this compulsive re-enactment by providing an understanding of the traumatic events underlying the repetition (Hopkins, 1986). By acting out their repetitive play within the therapy sessions, and their expectations for relationships within the developing transference relationship, the therapist can provide an experience of a new, and different, relationship. Again other child psychotherapists writing from the Anna Freudian tradition argue that the child can relate to the therapist both as a transference object and also use them as an appropriate developmental object, that was perhaps missing from their previous parental relationships (Hurry, 1998; Ralph, 2003). This can facilitate the development of a basic sense of trust in an adult figure (Ralph, 2003). Barrows (1996) states that the eventual aim is to break the cycle of repetition by making unconscious memories conscious, and therefore relieving the need to compulsively act them out.

Collectively, the material presented in the sections above demonstrates the conceptual logic for using the psychoanalytic approach in individual therapy with children in local authority care. A common thread appears to be that the psychoanalytic approach is suitable when there is a need to produce deep-seated change, including helping deprived children to better understand what is preventing them from relating to others. Thus, the development of a relationship with a trusting, benign adult figure aims to facilitate the development of more meaningful and supportive relationships with others. Whilst there is a rich clinical account of both the theoretical perspectives influencing child psychotherapists' work with children in local authority care, and the presentation of these children in therapy sessions, this has primarily been written by therapists using individual case studies. Child psychotherapy – and psychoanalysis – has a long history of using individual case studies; the focus on unconscious ways of relating and the transference relationship as the mechanism of change presents notable challenges for research. Despite significant progress in conducting empirical research into psychoanalytic therapy with children (see section 2.6), traditionally, case studies have been adopted by those practising the psychoanalytic approach. Clinical case studies serve many functions including the assimilation of theory with clinical practice; providing a detailed understanding of clinical technique; and also generating new ideas (Midgley, 2006). However, it must be acknowledged that individual case studies have several limitations, which Midgley (2006, pp.126-7) classifies into three areas: 'the data problem'; 'the data analysis problem'; and the 'generalisability problem'. Firstly, therapists' personal accounts rely on both their memory and understanding of clinical sessions, which is unavoidably subjective, selective, and interpretive. Secondly, the relatively unsystematic way in which case studies are traditionally written means they are prone to the writer putting material together in such a way as to argue their point of view. This could mean that material is selected and analysed that 'fits' with the therapists' own theoretical perspective, while material that contradicts this is discounted. Thirdly, case studies have been widely criticised for their inability to generalise to broader populations than the individual under study. While Midgley (2006) suggests a number of ways in which these limitations can be overcome – for example adopting a more systematic and explicit methodology to analysing case material – the extent to which these techniques have been used by child psychotherapists writing about their work with children in local authority care is

unclear. Despite these limitations, the clinical material presents the conceptual logic for using this approach with children in local authority care and demonstrates that child psychotherapy is being used in routine clinical practice with these children, while also highlighting the particular challenges of working with this population.

2.4 What are the challenges of working psychoanalytically with children in local authority care?

Whilst the previous section discussed potential ways in which child psychotherapy may be appropriate as a treatment for children in local authority care, it is clear from child psychotherapists' descriptions of their work that it can be immensely painful to both witness the levels of deprivation experienced, and also to cope with the extreme behaviours and difficult emotions expressed by many children. Angry, aggressive behaviour is the hallmark of many of these children and can make it exacting for the therapist to manage the sessions. Boston & Szur (1983, p. 58), in their description of psychotherapy with children at the Tavistock clinic, recall that all therapists had been subject to the projected emotions of these children, made to feel 'useless, helpless, rejected, abandoned, messed up or cruelly treated'. In the first instance, therapy sessions may be about maintaining the child and therapists' physical safety within the room (Hoxter, 1983). Canham (2004) discusses safety measures that can be taken, such as removing hard toys or moving furniture that can be jumped off or thrown about. Added to this is the difficulty for the therapist to keep holding the child in mind when confronted with such assaults; Canham (2004, p. 121) notes that the 'mental composure' of the therapist is shaken when faced with such an onslaught. In contrast to these perspectives, Music (2009, p. 153) describes the somewhat different feelings that may be elicited in the child psychotherapist when working with a 'cut-off' neglected child, 'from feeling de-skilled, and dehumanised to plainly and simply bored, and we can also feel dislike and coldness.'

The impact on the child psychotherapist can be considerable. Several have discussed the difficulties for the therapist in being able to keep thinking for the child, and of ensuring that they do not retaliate (Boston & Szur, 1983; Canham, 2004; Hoxter, 1983). Canham (2004) discusses the dilemma between the therapist becoming the abuser, such as retaliating or making persecutory interpretations, and the abused, such as allowing the child to endlessly evacuate their emotions whilst

collapsing under the pressure themselves. Kenrick (1991) discusses the effects of projective identification on her as it led her to breakdown not just in therapy sessions, but also in her personal life. Lanyado (2003) also describes feeling bewildered and overwhelmed by a child's aggressive behaviour, despite her understanding of the countertransference. Jackson (2004) and Rustin (2001) describe the difficulty for the child psychotherapist of maintaining a stance of 'bearing witness' to the child's behaviour (in these cases, sexualised behaviour), whilst not acting voyeuristically. The therapists' difficulties with handling the situation can also further impact on the child. Sutton (1991) proposed the term 'triple deprivation' to add a further layer to Henry's (1974) definition of double deprivation. Sutton's suggestion is that the therapist may act as another source of deprivation to the child, because of countertransference feelings and also organisational pressures impacting on the therapist's ability to remain emotionally available to the child. Music (2009, p.143) relates this triple deprivation clearly to those children who have experienced neglect, in that these children may easily slip 'out of sight and out of mind', with a tendency to not display such acting out behaviour as those children with more obvious abuse histories. Some child psychotherapists have highlighted the importance of supervision and organisational support around the therapist in order to manage feelings aroused in this work (Canham, 2004), however little is known from the existing literature about specific ways in which child psychotherapists can prevent the effects of 'triple deprivation' from occurring and how they manage feelings aroused in this work.

2.5 What is known about the format and content of psychoanalytic work with children in local authority care, both inside and outside the therapy room?

Given the potential of this approach as a mental health treatment for children in local authority care, it is necessary to understand the nature of the work being undertaken by child psychotherapists, and their role in working with these children. The focus of the clinical literature has largely been on the child's internal world and their presenting problems. However, some thought has been given to ways of working with this population. This section discusses the state of knowledge about child psychotherapists' practice with children in local authority care both in individual

therapy, and work 'outside the therapy room', with their professional network and foster carers. As will be demonstrated, the available literature primarily comprises child psychotherapists' individual case studies, the strengths and limitations of which have already been discussed.

2.5.1 Individual therapy with children in local authority care

Clinical material on child psychotherapists' work with children in local authority care mainly comprises descriptions of developing the therapeutic relationship and therapeutic interventions. The complex needs and traumatic histories that many of these children present with has led several child psychotherapists to note that psychotherapy can be quite distinct from traditional forms of practice (Boston & Szur, 1983; Hunter, 2001). Whilst there are likely to be differences in the way that child psychotherapists work according to their theoretical orientation, there also appear to exist some commonalities in approaching therapy with this group. For highly vulnerable and traumatised children, it has been argued that the psychotherapeutic relationship can be perceived as overwhelming and felt as too 'intimate' (Kenrick, 2006). As such, there is evidence to suggest that therapists need to approach the relationship with caution, giving much consideration to what is said in sessions, as well as the timing of interventions (Kenrick, 2006). Rustin (2001; 2006) argues that short-term interventions are insufficient to address the depths of psychological damage endured by these children; it can take a long time for them to begin to break down their deeply entrenched defences, and therefore the therapist needs to 'tiptoe' up to their pain (Rustin, 2006, p. 125). Robson's doctoral research (2014) similarly interviewed child psychotherapists about their work with children in local authority care, finding they were quite restrained in their approach, allowing the child to set the pace of sessions. Therefore, having the time and space necessary to build the therapeutic relationship at a much slower pace, appears to be crucial.

In particular, numerous child psychotherapists have stressed the importance of the therapist not interpreting too early into the transference relationship, as the trauma experienced by many of these children may mean that they perceive interpretation as an attack (Gibbs, 2006; Jackson, 2004; Kenrick, 2005, 2006; Lanyado, 2008; Marsoni, 2006; Strati, 2007). Kenrick (2006) states that returning the

child's projection to them too soon may increase their feelings of persecutory anxiety, and therefore return them to their reliance on non-thinking defences. For example, with children who are aggressive, they may be identifying themselves with the victim in this context, rather than the perpetrator; highlighting the child's own violence may be perceived as unwarranted and unjust (Boston & Szur, 1983).

It has been proposed that the therapist, at least in the initial stages of the relationship, may simply need to describe what is happening in the room and the child's play, rather than interpreting (Marsoni, 2006, Kenrick, 2006). Over time these initial observations could be developed into more emotive language (Kenrick, 2006). Kenrick (2005), writing from a Kleinian perspective, discusses the shift she feels is necessary from traditional Kleinian technique. While Klein felt that interpretations should be made quickly in the transference relationship, Kenrick (2005) differs when working with children in local authority care and suggests that transference and countertransference feelings should be held on to much longer. Alvarez's (1997) description of work with a borderline psychotic child has delineated this process and been applied to work with looked after and adopted children (Marsoni, 2006; Strati, 2007). Alvarez describes the need of the therapist to hold onto the child's projections of their parent within themselves, gradually unearthing their feelings, thus moving from what she terms a 'grammar of explanation' to a 'grammar of description' (p. 755-756). Lanyado (2003) also discusses what she terms the 'quietness' of the therapist when working with traumatised children, finding that as therapy progressed she and her patients often became *less* verbal, rather than trying to encourage them to talk. She describes this as an active rather than passive process; the therapist chooses not to comment or make interpretations. This contrasts with Hunter's (2001) perspective that when working with some children in local authority care, she had to be *more* communicative, finding that silence could be frightening for the child. This perhaps demonstrates the distinct approaches child psychotherapists are taking to approaching therapy with this group of children, and a need to be flexible and tailor their approach to the individual child. Several child psychotherapists have also noted that there comes a time in the therapeutic relationship when interpretations have to be made. Lanyado (2003) describes gradually managing to communicate the thoughts and feelings that were projected into her, while Kenrick (2006) discusses the therapists' dilemma of missing opportunities by interpreting too late. Hurry (1998) perceives that the child psychotherapist needs to carefully consider the wording used

when making interpretations with traumatised children; for example a child may not welcome an observation that they are re-enacting previous abusive experiences in the therapy room, but instead may need to hear that their therapist will not repeat the abuse they endured.

If child psychotherapists working with traumatised children are holding on to the transference and countertransference feelings, what, therefore is their role, at least in the initial stages of therapy? Many child psychotherapists have used Bion's term and suggested that it is to provide a containing function, remaining emotionally available for the child (Gibbs, 2006; Lindsey, 2006; Marsoni, 2006). This can be a lengthy process of being receptive to the child's communications and having to survive and bear the child's projected emotions (Lanyado, 2003; Lindsey, 2006). Lanyado (2003, p. 21) describes being in a 'therapeutic reverie' during therapy with traumatised children; a state of mind that allowed her to facilitate a quiet, calming and healing environment, and likening it to bedside nursing of an ill person until they return to health. Demonstrating that the therapist can hold the child in mind can be a useful technique, for example Jackson (2004) describes games of hide and seek with an adopted child. However, Kenrick (2005) discusses the delicate balance between containing the child's fears and anxieties, whilst not doing this unbearably so. For such vulnerable children, experiencing containment too closely could be perceived as persecutory, reminding them of the deprivation they have previously experienced and that this experience of containment has been missing from their lives.

Lanyado (2003) discusses the dilemmas of undertaking therapy with children 'in transition'; that is, transitioning between fostering and adoption. She feels the notion of the therapy room as a transitional space is paramount, applying Winnicott's (1953) ideas. Lanyado sees the therapy room as a space 'in-between' (p. 80); not belonging to either the child or therapist, and thus allowing the creation of a unique relational experience that slowly develops from the many experiences the child has with the therapist. Lanyado believes that the establishment of the transitional space is crucial to promoting therapeutic change. However, she also discusses difficulties with establishing this space, noting that initially traumatised children may view the space as 'more like a chasm or terrifying gap than a place in which it is possible to become more alive.' (p. 82). Lanyado's descriptions of therapy with children 'in transition' pose a question of whether psychotherapy is appropriate for children in

local authority care at certain timepoints in their lives, for example, those transitioning to adoption, or not in stable placements, which has largely not been explored by the literature.

Other methods of connecting with these children have been proposed. In particular, the need for the therapist to be creative and flexible (Gibbs, 2006; Rustin, 2001), such as their willingness to engage in playful behaviour. Music (2009, p. 152) has criticised traditional psychoanalytic technique for predominantly focusing on interpretation of the child's defences, arguing that with deprived children there is a need to engage in playful behaviour with the therapist, as a means of developing their sense of 'aliveness'. This shares similarities with Lanyado's (2017) discussion of the importance of nurturing developmental growth within the therapeutic relationship, for example with a child that cannot play, it is the therapists' role to pay close attention to noticeable signs of this capacity, and then slowly nurture it within this safe space. She feels that the therapist may sometimes have to take calculated 'risks' to encourage the child's growth when they feel that the timing is appropriate (Lanyado, 2017). The therapist may also need to use alternative methods of communicating with these traumatised children (Jackson, 2004; Rustin, 2001). Jackson (2004), in describing therapy with an adopted child with a history of severe trauma, felt that simply describing the child's play was insufficient in allowing a connection to develop between them. Instead he describes a magnified mirroring response to her actions, for example expressing exaggerated shock when he felt that she was experiencing this emotion herself. Jackson felt this response was helpful in breaking the cycle of repetition in the girl's play and her behaviour; this mirroring was a form of interpretation, by showing an empathy with the level of trauma she was experiencing. This resonates with the concept of 'marked mirroring' within the mentalization literature. Mentalization is the capacity to interpret the intentional mental states of self and others (Bateman & Fonagy, 2006); marked mirroring describes a process whereby a parent or caregiver, in reflecting on the child's state of mind, regularly 'mirrors' back the infant's feelings. The mirroring is contingent in that the caregiver's speech or expressions accurately represent the child's emotions, but also 'marked' in that it is distorted enough that the infant recognises it is not the caregivers' own emotions (Fonagy et al., 2002). Repeated experiences of this allow the child to understand, and eventually control their own thoughts and feelings, develop a coherent sense of identity, and other skills such as

empathy. Jackson's (2004) description of therapy with a traumatised child, of helping her to be aware of her own mind, suggest that psychoanalytic work with these children could, at times, overlap with theoretical perspectives outside of classical psychoanalytic technique, namely similar to mentalization-based treatment (Bateman & Fonagy, 2006). Similarly, Music (2009) describes the use of amplified imitation as a means of connecting with a neglected child, feeling that repeated experiences of this encouraged a sense of playfulness, and eventually, developmental growth. Although Music (2009) links this process to Fonagy et al.'s (2002) ideas, for the most part, the child psychotherapy clinical literature has not framed technique with children in local authority care using a mentalizing perspective.

Collectively, child psychotherapists' case studies of individual therapy suggest that shifts to traditional technique may be needed with children with experiences of trauma or maltreatment. A consistent description is the therapist's central role of acting as container for the child's mental states, and in often using non-interpretive ways of communicating with these children, at least in the initial stages of therapy. While the clinical material suggests that there is a need for a lengthy engagement period of therapy – and therefore that longer-term treatment may be needed – it is unclear whether this is reflected in practice; particularly as it is typical for child mental health services to routinely offer time-limited therapy (Bent-Hazelwood, 2020). This poses the question of whether child psychotherapists are, in practice, able to offer the approach they feel is most appropriate for the child. Furthermore, given that much of the clinical literature was written some years ago, there is a need to understand the theoretical frameworks that child psychotherapists are currently drawing on in their models of working with children in local authority care.

2.5.2 Psychoanalytic work in the children in local authority care field 'outside the therapy room'

In addition to individual psychotherapy, child psychotherapists in the UK provide several other services to professionals and foster carers who work with children in local authority care. These include consultation with the professional network; group or individual/couple work with foster carers; supervision; teaching; and training.

Consultation is a core aspect of a child psychotherapist's work across many different settings. Consultation has been defined as distinct from supervision, in that the professional responsibility for the work lies with the person seeking advice, whereas in supervision, the supervisor assumes managerial responsibility for the work (Wilson, 2009). Consultation can be requested by a range of different agencies, often to increase understanding of a child's presenting problems, or to enhance professional expertise in therapeutic technique and psychoanalytic understanding (Crockatt, 2009). Consultation may also include reflective practice elements, and several models of reflective practice are based on the psychoanalytic approach; including the relationship-based model of reflection (Ruch, 2007) and work discussion groups (Rustin & Bradley, 2008). These draw on ideas including Bion's (1962) work and Bick's (1964) method of child observation. In Ruch's (2007) model, professionals meet as a group, which begins with a practitioner presenting a case. Group members then engage in discussion focused on promoting curiosity, tolerating uncertainty, and containing emotions. The work discussion model is a core element of child psychotherapy training, in which professionals again meet as a group, usually bringing cases for discussion, and have space to reflect on a child's behaviour and communications, as well as thinking about the role of the worker and the task of the organisation (Rustin, 2008). The model has been adopted in other environments such as education (see Jackson, 2008; Rustin & Bradley, 2008) and health settings (see Rustin & Bradley, 2008), and local authority residential assessment centres for children in local authority care (Hannah, 2008). Evaluation of a schools-based work discussion model found that regular groups have numerous benefits for staff, including increased professional confidence and reflective practice skills, and deeper understanding of and ability to manage teacher-student relationships (Jackson, 2008).

Although the above literature demonstrates that models of consultation based on psychoanalytic ideas are being used, and evaluated, with professionals in different settings, relatively little has been written specifically about child psychotherapists' consultation work with the professional network around children in local authority care. The literature that does exist suggests that child psychotherapists perceive this to be an integral component of their work within this field (Emanuel, 2002; Hunter, 2001; Rocco-Briggs, 2008; Sprince, 2000). This literature will be reviewed further in Chapter 4.

Despite a scarcity of literature on child psychotherapists' work with the professional network, psychoanalytic ideas about the functioning of organisations provides a relevant framework for understanding how professionals working in healthcare, and related fields such as social work, manage emotions generated by the nature of the work. Several theoretical and analytical papers have proposed that practitioners can develop a variety of techniques to defend against unbearable feelings and anxieties aroused by their working environments, which can then become replicated at the systemic level, becoming a part of the organisational culture (Hinshelwood & Skogstad, 2000; Jaques, 1955; Menzies-Lyth, 1960). These ideas have led to the development of consultant led groups aiming to tackle these unconscious 'blocks' that disrupt the task of the organisation (Obholzer & Roberts, 1994). The underlying premise is that if professionals' experiences can be thought about and made sense of, ultimately, they can manage the feelings encountered in their work more appropriately (Menzies-Lyth, 1960). This literature will again be discussed in more depth in Chapter 4 but demonstrates the mechanisms by which psychoanalytic consultation may affect change in professionals working with children in local authority care, who commonly work in emotionally challenging environments.

Literature on child psychotherapists' work with foster carers is again sparse. The available literature is predominantly in the form of clinical material and suggests that child psychotherapists can provide both therapeutic support and training to foster carers (Barratt, 2015; Emanuel, 2002; Hunter, 2001; Ironside, 2004, 2009, 2012; Rocco-Briggs, 2008; Sprince, 2015). This literature will be reviewed further in Chapter 4. Despite clinical material providing some indications of the child psychotherapists' role in working with foster carers, empirical research on this area of practice is very limited. There is evidence of some mentalization-based interventions focusing specifically on work with foster carers. Mentalization-based treatment is an integrative treatment, combining ideas from psychoanalysis and fields including attachment and neuroscience research (MBT; Bateman & Fonagy, 2006). The Reflective Fostering Programme (Redfern et al., 2018) is a UK group-based programme, rooted in a theoretical model integrating mentalization, attachment, and social learning theories. The programme aims to promote foster carers' mentalizing or parental reflective functioning, in turn aiming to improve their sense of parental efficacy, strengthen the parent-child relationship, and thereby promote placement stability. The programme consists of ten sessions delivered to a

group of foster carers (n= 8-10) over several months. Preliminary pre-post evaluation measures of 28 foster carers found a significant improvement in both carer-focused outcomes (ratings of parenting stress and the degree to which they met personally defined goals) and child-focused outcomes (ratings of child's emotional regulation and strengths and difficulties). However, non-significant changes in foster carers' reflective functioning were found (Midgley et al., 2019). Whilst findings are encouraging, they are only preliminary, with a small number of participants and no control group, and child improvements were solely rated by the foster carers.

Another intervention designed to increase foster carers' capacity to mentalize, this time in the US, is the Family Minds psychoeducational programme (Adkins et al., 2018; Adkins et al., 2021). Adkins et al. (2021) reported on an RCT of the programme, in which 89 foster carers received either Family Minds, delivered over three, three-hour sessions, or a control group who received a four-hour foster training class. After six weeks, foster carers in the Family Minds group showed significant improvements on one measure of reflective functioning (by a lowering of pre-mentalizing states), and decreased parenting stress regarding challenging parent-child interactions, compared to the control group. Again, while these results are encouraging, there were no significant differences between the groups in terms of other measures of reflective functioning or parenting stress, nor did the intervention significantly improve the child's emotional and behavioural difficulties after six weeks, in comparison to the control group. Furthermore, the study's sample was again relatively small and there was a high attrition rate. Despite this empirical evidence concerning MBT-based interventions with foster carers, there is only very limited research concerning specifically psychoanalytic ways of working with foster carers. This will be reviewed in Chapter 4 (Ironsides, 2009, 2012; Onions, 2018).

Collectively, it can be concluded that there is a distinct lack of research examining the range of work conducted by UK child psychotherapists outside the therapy room. This includes the prevalence of consultation work with the professional network and support to foster carers. Research is also lacking on child psychotherapists' experiences of their role as consultant to the professional network and foster carers, as well as other professionals' perceptions of the child psychotherapists' role, including the views of social workers as the agency with key responsibility for these children. Furthermore, while there is a body of literature concerning psychoanalytic perspectives on organisational functioning, and this

framework can be applied to psychoanalytic consultation with professionals, most of this literature has been related to healthcare settings. Although some limited studies and critical analysis papers have applied these concepts to social care as an organisation (e.g. Cooper, 2010; Ferguson, 2018; Lees et al., 2013; Rustin, 2005; Whittaker, 2014; this literature is reviewed further in Chapter 4), little has been written pertaining this perspective specifically to children in local authority care, and indeed whether UK child psychotherapists draw on this framework – or others – during consultation.

2.6 What does the evidence indicate about the effectiveness of psychodynamic therapy² for children with experiences of trauma or maltreatment?

This section provides an overview of the research evidence for psychodynamic therapy with children with traumatic histories, and specifically with children in local authority care, including areas lacking research evidence that require further exploration. Historically, psychodynamic treatments have lacked an empirical evidence base, being perceived as overlooking empirical measurement in favour of clinical judgement (Midgley & Kennedy, 2011; Tarren-Sweeney, 2013b). In recent years increasing empirical research has been conducted into psychodynamic therapy's effectiveness with children and adolescents, and some treatment manuals of psychodynamic therapies have been published (e.g. Cregeen et al., 2017; Göttken & von Klitzing, 2013; Hoffman et al., 2015) alongside review articles synthesizing the evidence base (Abbass et al., 2013; Midgley & Kennedy, 2011; Midgley et al., 2017; Palmer et al., 2013). Collectively, the research suggests that there is some support for psychodynamic therapy being an effective intervention for children and adolescents with a range of clinical diagnoses. However, much of the research is hampered by small sample sizes and/or uncontrolled studies.

² The term 'psychodynamic therapy' will be used in this section as a broader umbrella term than 'psychoanalytic therapy', to incorporate research that uses a wide range of approaches that can be classed as 'psychodynamic'.

Although limited, there is some evidence from outcome studies to suggest an effect of psychodynamic treatment for children with histories of trauma or maltreatment. Trowell et al. (2002) used a randomised design to compare individual psychodynamic psychotherapy (up to 30 sessions) to a psychoeducational group therapy (up to 18 sessions) among 71 girls aged 6-14 with sexual abuse histories. Both groups also received parent/carer work. The study was based at two treatment centres in London and both treatments were accompanied by support from carers. Assessments conducted one year after treatment, and at two-year follow-up, showed both therapies to be similarly effective in reducing psychiatric symptoms and improving global functioning. However, the individual treatment was more effective in reducing PTSD symptoms. A limitation of this study is that ethical reasons precluded the addition of a control group with which to compare the effects of both treatments against.

Gilboa-Schechtman et al. (2010) conducted a pilot RCT of a CBT based treatment (prolonged exposure therapy for adolescents; PE-A) for 38 Israeli adolescents diagnosed with PTSD after experiencing a single-event trauma. A time-limited dynamic therapy was used as the control condition. At six and 17 months post-treatment, participants in both groups significantly improved in their general functioning as measured by the Child Global Assessment Scale (CGAS; Shaffer et al., 1983), and had less depressive and PTSD symptoms. Although the PE-A treatment produced greater gains than the psychodynamic one at six months follow up, by 17 months post treatment, these differences had disappeared; perhaps lending support to the notion of a prolonged, 'sleeper' effect of psychodynamic psychotherapy. This was only a pilot RCT so the number of participants in each group was small. However along with Trowell et al.'s (2002) study, both using randomised designs, it does provide some evidence that psychodynamic psychotherapy can be effective with children with experiences of trauma or maltreatment, albeit with quite heterogenous groups.

Studies focusing specifically on children in local authority care in the UK are sparse. A study was undertaken at the Tavistock between 1988 and 1994, evaluating psychodynamic psychotherapy for 31 children either in foster care, adopted or in residential homes (Boston, 1989; Boston et al., 1991; Boston & Lush, 1994; Boston et al., 2009). The children either received once weekly therapy, or more intense therapy 2-3 times weekly. At baseline, the children's therapists were

asked to record the aims of therapy, and to rate the child's expected progress on a 5-point scale. After up to two years of treatment, the therapists rated actual progress on the same scale, including an additional option for those rated as 'worse'. The findings showed that 26 of the 31 children were rated as showing 'some degree of improvement' (and 23 of these were rated as 'definite' or 'considerable' improvement). Four children were rated as 'doubtful progress' and one as 'no change'; none were rated as worse. Some external checks were made to compare with the therapists' ratings. Firstly, reports from the professional network around the child were used. Secondly a 'blind' rater used the same progress form as the therapists to rate progress after reviewing records of early and later therapy sessions. In 26 cases, the external criteria for progress was met. Children in the psychotherapy group were compared to a contrast group of children for whom psychotherapy was recommended but not received; the researchers concluded that the groups were 'not substantially different' based on analysis of their care histories. None of the children were described as better in the contrast group at two year follow up, however information was only available on seven cases. Therefore, comparison with the contrast group led the researchers to suggest that psychotherapy might have been the mechanism of change. The improvements noted in the children in the psychotherapy group included: positive changes in intellectual functioning, better relationships with peers and siblings, and increased trust and security in external figures. This study was a novel approach to studying psychotherapy among children in local authority care, as well as using a research methodology that did not impact on normal clinical practice (Boston et al., 2009). Despite these positives, there are some distinct limitations to the study: the number of participants was too small to detect significant differences in changes; progress was determined by external raters; and a contrast group was used rather than a control group.

In a Scandinavian study, Heede et al. (2009) investigated milieu-therapy (an approach based on psychodynamic object-relations theory) among 25 children aged 6-15 years with histories of severe deprivation and trauma, living in residential units. They found significant changes in the children's personality after two years of treatment, including better cognitive and ego functioning. Although promising, these findings again should be taken with some caution because of the lack of control group and small sample.

Clausen et al.'s (2012) US study reports on the outcomes of 20 foster children (aged 5-10 years) receiving 'A Home-Within'; a relationship-based intervention utilising psychoanalytic psychotherapy and play therapy. The intervention was long-term, 'for as long as it takes' (with a mean treatment length of 3.37 years, SD = 2.16). Significant reductions were found in many areas of psychological dysfunction, namely anxiety, depression, peer relationship problems, aggression, sleep disturbance, dissociative problems, and school problems. However, limitations to the study include a small sample size, outcomes that were based on therapist reports of progress, and no comparison group.

Some research has investigated mentalization-based approaches for looked after and adopted children. Ingley-Cook and Dobel-Ober (2013) describe a group treatment programme for looked after and adopted children attending a UK CAMHS service (Ingley-Cook & Dobel-Ober, 2013). The programme comprised eight sessions for 11 participants aged 9-16, divided into two groups based on their ages. Evaluation included interviews with the children before and after treatment, concerning their goals for therapy. Of the nine children who listed goals at the beginning of treatment, all of them said that by the end of treatment they had either fully or partially achieved them. Participants also reported learning about affect regulation, and felt they benefitted from having the programme delivered in a peer group setting. At the time of publication, this study was in its initial stages of service evaluation, with a very small sample, no control group, and no definitive or standardised outcome measures.

Another study using MBT undertook a small (n=36) RCT in a CAMHS team in Hertfordshire. The Herts and Minds project aimed to assess the feasibility of MBT for foster children with emotional and behavioural difficulties (aged 5-16), to determine whether it is feasible to conduct a larger trial (Midgley et al., 2017; Midgley et al., 2019). This study used a short-term (up to 12 sessions) manualised MBT, targeting the specific needs of children and their carers, principally on improving secure attachment and promoting mentalizing in the foster carer. The MBT treatment was compared to a control condition of usual clinical care, of equal length. A range of quantitative and qualitative measures were used, at baseline, 12 weeks post-randomisation (when therapy may have been completed), and 24 weeks post-randomisation. The only findings published so far relate to the feasibility of running a larger study, indicating that overall, a full scale RCT is possible, with some

adaptations (Midgley et al., 2019). The study did not have sufficient statistical power to detect differences in outcomes between the groups.

Taken together, these studies show that there has been an increase in research concerning psychodynamic therapy with traumatised children in recent years. Much of the research is still in its infancy and is currently limited by small samples, lack of control groups, and other problems such as reliance on therapist reports. However, some studies are ongoing, while other pilot studies have shown promising findings. Whilst there currently exists a limited evidence base for psychodynamic psychotherapy with traumatised children, initial evidence of its effectiveness suggests a pressing need for further research into this approach with children with histories of trauma or maltreatment. This is particularly so specifically for children in local authority care, for whom there is only limited research evidence in existence.

2.7 Conclusion

This chapter has highlighted how psychoanalytic ideas have been used in thinking about work with children in local authority care, and ways in which the approach may affect change in these children. While the conceptual logic for using this approach has been discussed, much of the literature is in the form of individual case studies, thus indicating a need for further empirical research. This is pertinent given the calls for treatments potentially suitable for children with complex trauma or attachment related issues, for which other approaches may be insufficient (Luke et al., 2014). Given previous debates over the appropriateness of this approach for children with traumatic histories, there is also a scarcity of research exploring current perceptions amongst child psychotherapists around whether it appropriate; and if so, why. Furthermore, the clinical material indicates potential challenges of working therapeutically with this population of children, therefore understanding current perceptions and practice amongst UK child psychotherapists about the suitability of the psychoanalytic approach with children in local authority care is relevant. There is also a need for research to establish whether the psychoanalytic approach is tenable with this whole population of children, and if so, under what conditions.

Furthermore, the chapter has described the application of the psychoanalytic approach in both direct therapeutic work with children and in broader work with the

professional network and foster carers. Finally, this chapter has reviewed the evidence-base for this work with children with traumatic histories, and specifically those in the care system, for which there is only very limited research in existence. The extent to which psychoanalytic therapy is being used with children in local authority care in the UK has not been studied, as well as the nature, range, and context of treatment. This includes the most common presenting problems of children in local authority care seen in psychoanalytic therapy; the context of therapy sessions (individual /with caregivers present /group therapy), and the length of therapy commonly being offered. Little is also understood about the services that child psychotherapists are working in when undertaking therapy with children in local authority care, for example whether these mostly comprise generic CAMH services, or whether they are also working in more specialist mental health services for children in local authority care. This is pertinent given the literature reviewed in Chapter 1, which identified that children in local authority care's mental health needs are often poorly matched to the services that generic CAMHS are designed to offer, resulting in the introduction of targeted services for these children. As so little is known about current ways of working with children in local authority care amongst UK child psychotherapists, this is a useful starting point for research.

Empirical research is also lacking on the other aspects of child psychotherapists' work with these children, including work with the professional network and foster carers. The importance of professionals working with children in local authority care accessing appropriate consultation and support from agencies including mental health professionals, has been emphasised (Hiller et al., 2020; NICE/SCIE, 2010a). However, the extent to which child psychotherapists are working with the professional network and foster carers has not been documented, nor is their role in working with them clear.

These are the gaps in knowledge that this research initially seeks to address through the first study. Further research questions arising as the research progressed will be discussed in the chapters that follow.

3 Study 1: A national survey of UK child psychotherapists' work with looked after and adopted children

3.1 Introduction

The overall aim of this thesis is to explore psychoanalytic ways of working with children in local authority care, and the role of UK psychoanalytic child psychotherapists in this field. Given the lack of research on child psychotherapy with these children as discussed in the previous chapter, the starting point for this thesis will be to identify the extent to which this treatment is being used with these children in the UK, as well as the nature, range and context of treatment. This chapter describes the first study of the thesis, a survey of UK child psychotherapists about their work with looked after and adopted children. Preliminary literature is presented first, before the findings of the survey itself, which are used to inform the next phases of the research.

There is a distinct lack of literature about the activities of child psychotherapists in the UK. The only available national surveys of the profession are audits conducted quite some time ago; one in 1987 (Beedle & Payne, 1987) and two in 2003 (Rance, 2003; Sherwin-White et al., 2003). These focused on the range of children seen in psychotherapy, and the working contexts of child psychotherapists. One of the most recent studies (Rance, 2003) surveyed 213 child psychotherapists concerning 1,025 children in therapy; the vast majority of respondents (89%) were working in NHS settings. Most work was conducted with children aged 5-11 years (47.4%) and 12-16 years (36.5%), and the most common format of sessions was once weekly (73.9% of children). Both the Beedle and Payne (1987) and Rance (2003) surveys found that respondents reported complex difficulties amongst many of the children in therapy. Over a quarter of the children (26.6%) in the Rance (2003) survey had a psychiatric diagnosis, and the majority (63.2%) had the involvement of another agency, commonly social services. Similarly the respondents in Beedle and Payne's (1987) survey rated three quarters of the children in therapy as being

severely or very severely unwell, also finding that respondents rated 29% of their referrals to psychotherapy as a 'last resort' option, possibly because other treatments had been unsuccessful with these children (as cited in Kam & Midgley, 2006). Interestingly, Rance's (2003) survey found that 15.6% of the children were living with foster carers and 9% with adoptive parents, observing that this was a sizeable increase from the Beedle and Payne (1987) survey. It is worth noting that Rance's (2003) survey focused only on children who were in long-term psychotherapy; there is a widespread perception that child psychotherapists typically undertake longer-term work (Petit & Midgley, 2008). However, this potentially excludes other types of therapy, such as short-term work. Furthermore, the Sherwin-White et al. (2003) survey identified a much broader range of activity amongst child psychotherapists, including assessment, consultation, work with families, supervision, and teaching. Furthermore, this survey identified the vast range of contexts that child psychotherapists were working in, extending much further than the traditional NHS CAMHS where the majority of the profession are employed.

Although these are the only national audits available, some smaller scale research has been conducted of child psychotherapists' activities within a specific CAMH service. Kam (2004) undertook an audit of child psychotherapy referrals in a London CAMHS over a five-year period, also finding that direct therapy with children only comprised one aspect of therapists' work within the service (18% of 220 referrals). Assessment work, as well as work with parents and families, comprised a larger proportion of referrals to the service (46% and 31% respectively), along with other activities, to a lesser extent (e.g. consultation work, 5%). Petit and Midgley (2008) built on Kam's (2004) study by focusing specifically on assessments conducted within the same CAMH service during the same period. They found that a range of assessment work was conducted, including assessments not necessarily for psychotherapeutic treatment, for example, assessments for court or social services. Both these studies either included (Petit & Midgley, 2008), or followed up with (Kam & Midgley, 2006), a qualitative exploration of the initial audit. Kam and Midgley (2006) conducted interviews with service practitioners to explore clinical judgement and decision making in referring cases for child psychotherapy, while Petit and Midgley (2006) explored further the nature and process of the assessment work. Combined, these studies provide some insight into the activities of child psychotherapists within a single CAMH service, particularly shedding light on

alternate activities to individual psychotherapy, that are forming a major part of child psychotherapists' work. However, the studies were small-scale and only focused on one geographical location and workplace setting.

Ultimately, although some research has been conducted into child psychotherapists' activities in the UK, there is a paucity of research at a national level in recent years. Furthermore, no surveys have been conducted of the profession focusing specifically on looked after and adopted children³. Given that previous surveys have highlighted the perception that child psychotherapists are commonly working with vulnerable children with complex difficulties, and that a proportion of these children are not living with their birth parents, this is an area worthy of further exploration. Moreover, given Sherwin-White et al. (2003) and Kam's (2004) findings, it is pertinent to explore other types of work that child psychotherapists are conducting with these children aside from individual psychotherapy, as well as other types of therapy aside from long-term work.

3.2 Study aims

The aims of this study were:

- To identify current psychoanalytic models of working with looked after and adopted children amongst UK child psychotherapists. This includes direct work with children, as well as assessment, work with the professional network, and research and evaluation.
- To explore child psychotherapists' perceptions about therapeutic work with looked after and adopted children and their professional network, and what they think is the contribution that child psychotherapy can make to these children.

³ In this chapter, the term 'looked after and adopted children' will be used. This is because it is the term typically used by UK local authorities and other services including CAMHS, and was therefore used to describe these children during the data collection process.

The primary research question was: what is the current nature and provision of psychodynamic models of intervention for looked after and adopted children in the UK?

3.3 Methods

3.3.1 Research design

This was an online survey capturing information on the ways in which UK child psychotherapists were working with looked after and adopted children. The survey was cross-sectional and aimed to capture a snapshot of child psychotherapists' work with these children at the time of completion.

3.3.2 Ethical considerations

Ethical approval to conduct the survey was granted in February 2016 by the UCL Research Ethics Committee (Project ID: 8293/001, see Appendix 1). The Association of Child Psychotherapists' (ACP) chair also granted approval of the final survey questions.

Participants were required to give informed consent before completing the survey. The survey did not ask for any details of children or families that would breach confidentiality or anonymity. Information and consent forms can be found in Appendix 2.

3.3.3 Participants

Survey respondents were UK trainee or qualified child psychotherapists, and therefore members of the registered body, the ACP. The ACP is the professional body for psychoanalytic child and adolescent psychotherapists in the UK and is registered with the Professional Standards Authority. ACP members were eligible to participate even if they were not currently working with looked after and adopted children; the survey aimed to capture information about the proportion of members

who were actually working with these children in some capacity. Those working outside the UK were excluded. In total, there were 875 eligible members.

3.3.4 Survey instrument

A survey was designed to capture information on child psychotherapists' ways of working with these children. Looked after and adopted children were combined in the survey to make it less time consuming to complete. Although the questions did not differentiate between the groups, it was intended that later phases of the thesis might focus on one group. The survey was primarily quantitative; respondents were required to select answers from pre-defined categories or enter percentages. However qualitative questions and comments boxes were included so respondents could expand on their work, although they were not required to. An online consent form preceded the questions, including right to withdrawal, confidentiality, and anonymity procedures. Participants were required to give informed consent before proceeding. The questions comprised: respondents' workplaces and demographics; types of work undertaken with looked after and adopted children – namely, assessment, direct psychotherapy (meeting the child in person); work with foster carers / adoptive parents; consultation work; supervision; teaching / training; research / evaluation. These categories were broken down further to explore the nature of respondents' work, e.g. specification of treatment approaches; number of looked after and adopted children making up their caseload. A full list of questions can be found in Appendix 3. Respondents were asked to provide their name and email address at the end if they were interested in taking part in later phases of the research. Opinio, a web-based survey tool, was used to create the survey (ObjectPlanet, 2021).

Preliminary questions were piloted on six child psychotherapists with varying experience of working with looked after and adopted children. Four were female and one was a trainee. Participants were asked to give feedback on: the survey length; clarity of questions; appropriateness and inclusiveness of response options; technical problems encountered; layout and formatting. The survey was amended according to their feedback (see Appendix 4).

3.3.5 Procedure

The ACP administrator emailed an advertisement for the survey (including details of eligibility criteria), along with the survey link, to all ACP members. The survey was live for three weeks in March 2016. A reminder email, containing the survey link, was sent before the survey closed.

3.3.6 Data Analysis

The quantitative data was analysed using descriptive statistics; frequencies and percentages are presented for categorical variables and mean and standard deviation for continuous normally distributed variables. Chi-square tests of independence were used to compare the working patterns of trainee and qualified child psychotherapists. Fisher's exact tests were used where expected counts in the 2x2 contingency table were less than 5.

Qualitative data was analysed using thematic analysis (Braun & Clarke, 2006). The purpose of the qualitative analysis was to enrich the quantitative data, providing further insight into the nature of respondents' work and their views on working with looked after and adopted children and their professional network. This approach was chosen firstly because, as Braun and Clarke state, it is independent from a theoretical or epistemological position, unlike other approaches such as Interpretative Phenomenological Analysis (Smith et al., 2009) or grounded theory (Glaser & Strauss, 1967). This flexibility was appropriate for the analysis, given that the intention was to provide a descriptive account of child psychotherapists' activities, and not aiming to build theory, for example. This approach was also chosen because of its appropriateness for large data sets, which was the case in this study (Guest, 2012).

Braun and Clarke's (2006) method of analysis was followed. This included generating a list of codes from the data, organising them into potential themes and sub-themes, then revising these following discussions with my PhD supervisors (a more in-depth description of the thematic analysis process can be found in Chapter 4). The qualitative data analysis is presented under its respective quantitative data, i.e. relating to child psychotherapists' activities (assessment, direct psychotherapy,

work with foster carers/adoptive parents, consultation work). Although this is a descriptive approach, it fitted with the purposes of the analysis, which was to elaborate on the quantitative data. The data was therefore coded under these activity themes, and sub-themes were created within them. As an example, under the theme 'direct therapy with looked after and adopted children', the sub-theme of 'characteristics of the therapist' was created, which coalesced the initial codes 'non-judgemental therapist', 'flexible approach', 'consistency', 'able to tolerate projections', and 'therapists' own analysis'. Other sub-themes within the 'direct therapy with looked after and adopted children' theme were 'the uniqueness of the therapeutic relationship', 'the therapeutic setting', 'impact of child psychotherapy on looked after and adopted children', and 'occasions when psychotherapy is unsuitable for looked after and adopted children' (see Appendix 5 for a full list of themes).

During the coding process, it was apparent there was some overlap between codes (e.g. when asked about their assessment work, respondents often spoke about the consultation work this entailed). Therefore, the qualitative data presented within each section may come from a variety of codes (e.g. quotations under the 'consultation' section may come from qualitative questions asked in the assessment section).

In terms of the credibility of the analysis, as stated, I presented my initial analysis to my supervisors. This process of discussion allowed the analysis to be reviewed from different viewpoints, and then refined. Within the text, quotations have been used to support the analysis. A process of triangulation has also been adopted. The qualitative data has been compared to the quantitative data to show either the similarities, or differences, between them. Furthermore, quotations from respondents from different backgrounds have been used to show the representativeness, or differences, of perspectives. The source is presented in parentheses after the quotation, including the respondents' qualification status, gender, and location. The abbreviation CPT has been used for the word child psychotherapist.

3.4 Results

3.4.1 *Sample characteristics*

A total of 215 completed responses were received (24.5% response rate). Table 1 displays the respondents' characteristics. The majority were female (80.9%), and the largest proportion came from London (43.7%), followed by the South of England (23.7%), although all UK areas were represented to some degree. Over half of respondents trained at the Tavistock and Portman NHS Foundation Trust (58.6%), followed by the British Psychotherapy Foundation (formally the British Association of Psychotherapists; 14%), and then other training schools around the UK. Most respondents were qualified child psychotherapists (80.9%), with a mean number of 11.6 years qualified ($SD=8.8$, $n=173$). Furthermore, over half of respondents had worked with looked after and adopted children prior to training as a child psychotherapist (60%). The most common professions were: social worker ($n=39$), teacher/education settings ($n=22$), residential worker ($n=13$) and music/art therapist ($n=11$).

To assess the representativeness of the sample, these characteristics were compared to the demographics of the general ACP membership. At the time the survey went live, the ACP had 914 registered members, including those working abroad. Table 1 details the statistics on the breakdown of the ACP membership (where available), comparing them to survey respondents. Of the membership, 81% were female, and 18.3% were male. The gender breakdown of the survey respondents was therefore almost identical to the ACP membership. Qualified child psychotherapists made up 82.9% of the group, again very similar to respondents in this survey. A total of 322 members (35.2%) stated that they lived in London; unfortunately, information was not available on other locations. In terms of training schools, most of the membership attended the Tavistock and Portman NHS Trust (59.4%, $n=543$), again similar to survey respondents.

Table 1*Respondents' demographics, compared to those of the ACP membership*

	N	%	N	%
	Survey respondents (n=215)		ACP membership (n=914)	
<i>Gender</i>				
Female	174	80.9	741	81
Male	38	17.7	167	18.3
Missing	3	1.4	6	0.66
<i>Location</i>				
London	94	43.7	322	35.2
South England	51	23.7		
East of England	7	3.3		
Midlands	18	8.8		
North England	15	7		
Yorkshire	11	5.1		
Wales	2	0.9		
Scotland	11	5.1		
N. Ireland	4	1.9		
Missing	1	0.5		
<i>Qualification status</i>				
Trainee	39	18.1	156	17.1
Qualified	174	80.9	758	82.9
Missing	2	0.9	0	0

<i>Training school</i>				
Anna Freud Centre	9	4.2	48	5.3
Birmingham Trust for Psychoanalytic Psychotherapy	22	10.2	84	9.2
British Psychotherapy Foundation	30	14	116	12.7
Human Development Scotland	8	3.7	29	3.2
Lowenfeld/IPC	1	0.5	7	0.77
Northern School of Child & Adolescent Psychotherapy	17	7.9	60	6.6
Tavistock & Portman NHS Foundation Trust	126	58.6	543	59.4
Missing	2	0.9	9	0.99
Other	0	0	7	0.77
<i>Previous experience working with looked after and adopted children</i>				
Yes	129	60		
No	84	39.1		
Missing	2	0.9		

3.4.2 Workplaces with looked after and adopted children

Respondents were asked to record their general workplaces, as well as those where they worked directly with, or regarding, looked after and adopted children. Table 2 shows that respondents worked in a range of settings. In terms of general workplaces, NHS CAMHS were the most common, with 60% of respondents employed there. Private practice was the second most common (26.5%), followed by

targeted LAC teams based within CAMHS (17.2%); 36.2% of respondents had more than one setting where they worked as a child psychotherapist.

The ACP registers the workplaces of the general membership in a different way to the data collected in the survey; furthermore, information was only available on 565 of the 914 registered members, making it difficult to make comparisons. However, other studies (e.g. Petit & Midgley, 2008) have reported that most UK child psychotherapists work in CAMHS settings, as was the case in this survey.

The vast majority of respondents worked with looked after and adopted children in some capacity (87.9%). Three respondents indicated they were retired but had worked with these children previously. Workplaces with looked after and adopted children followed a similar pattern to general workplaces, with CAMHS (59.1%), targeted LAC team in CAMHS (20%), and private practice (15.8%) the most common places to work with or regarding these children. However, there was less work conducted with looked after and adopted children in private practice compared to 26.5% who worked in private practice generally. It was clear that respondents also worked in a wide variety of other settings, including the voluntary sector, specialist post-adoption services, educational settings and residential units. A total of 37.8% of respondents worked in more than one setting with or regarding these children.

Table 2*Respondents' workplaces*

	N	%	N	%
	General workplace		Workplace with looked after and adopted children*	
Tier 3 CAMHS	129	60	127	59.1
Private practice	57	26.5	34	15.8
Targeted LAC team in CAMHS	37	17.2	43	20
Voluntary sector / charity	17	7.9	12	5.6
Specialist post-adoption service	14	6.5	16	7.4
School	11	5.1	15	7
Hospital-based	9	4.2	5	2.3
LAC team in social services	7	3.3	9	4.2
Early years' service	6	2.8	5	2.3
Residential or inpatient unit	4	1.9	7	3.3
Court assessment team/service	3	1.4	4	1.9
Youth justice service	1	0.5	4	1.9
Other	24	11.2	19	8.8
Not working with looked after and adopted children**			26	12.1
More than one setting as a child psychotherapist	78	36.2	73	37.8
				(N=193)

*Some figures are higher than those for 'general workplace', because workplaces with looked after and adopted children also included consultations, training etc., which are not necessarily child psychotherapists' employed workplaces.

**excluded from further analyses.

3.4.3 Range of work conducted with looked after and adopted children

Respondents were asked to record which of seven possible activities they were currently undertaking with or regarding these children. Four activities were conducted the most frequently, namely assessment (83.7%, n=180), direct psychotherapy (82.3%, n=177), work with foster carers/adoptive parents (80.9%, n=174) and consultation work (76.7%, n=165). Supervisory work was conducted by just over half of respondents (52.1%, n=112). However, teaching and training (38.1%, n=82), and research and evaluation (26%, n=56) were conducted less frequently.

Within each activity category, respondents were asked further questions about the specific nature of their work.

3.4.4 Assessment

Table 3 shows a breakdown of the assessments undertaken by respondents. The most common were those assessing a child's suitability for psychotherapy (80%). Generic assessments as part of a multi-disciplinary team were conducted by over half of respondents (52.1%). These are likely to be standard procedural assessments at the initial point of referral to CAMHS.

There was also an indication that assessments were conducted for reasons other than treatment. State of mind assessments were the second most common form of assessment, conducted by around two thirds of respondents (66.5%). These are often requested by other professionals, or the courts (Petit & Midgley, 2008), and can provide insight into a child's emotions, without always leading to psychotherapeutic treatment. Nearly a fifth of respondents (19.5%) stated they were conducting other types of assessments; when asked to specify the nature of these,

many comments focused on assessing suitability of placements, or using specific tools such as the Story Stems Assessment Profile (Hodges et al., 2004).

Table 3

Assessments conducted regarding looked after and adopted children

	N	%
Assessing child's suitability for psychotherapy	172	80
Generic assessments as part of multi-disciplinary team	112	52.1
State of mind assessments	143	66.5
Other assessments for court	30	14
Other assessment	42	19.5
Not conducting assessments	9	4.2
Not applicable	26	12.1

The analysis of the qualitative data supported the range of assessment work conducted, and further elucidated the nature of this work. Assessments were viewed as a vital component of a child psychotherapist's work with these children; one respondent commented, 'the assessments and consultations provide a key foundation from which the work might begin.' (Trainee female CPT from London). Assessments frequently involved a diversity of approaches, lengths, and models of working, varying across services. Such approaches included liaising with the professional network, reading the child's records, and assessment/observation sessions with the child and/or foster or adoptive family,

Assessment may include consultations, foster home visits for babies and younger children, brief work with foster carers... reflective professionals meetings... transition support pre and post placement move... rehabilitation to family, contact reviews etc. (Qualified female CPT from London)

Supporting the quantitative data, several respondents commented that assessments with these children were not just used as a pre-cursor to treatment, but also for other reasons such as to inform court applications or care planning. One respondent commented, 'I am frequently asked to provide a report to support social services' application to proceed with [a] care order.' (Qualified female CPT from South England).

It was clear that assessment did not only mean working with the child individually, instead emphasising the importance of working with the network prior to, and during, the assessment phase. Respondents frequently reported that a number of people were often involved in the assessment process, including other professionals, foster carers/adoptive parents, and sometimes birth family. Although a distinction had been made between assessment and consultation work in the survey questions, respondents commonly emphasised the overlap between the two; often other professionals used the assessment period to seek a child psychotherapist's advice about a case, 'we have good ongoing relationships with several local authority social workers, who use the assessment format as a way of accessing consultation to themselves and their colleagues around difficult cases' (Qualified female CPT from the Midlands). In some services, child psychotherapists were working jointly with other professionals to undertake multi-disciplinary assessments, 'I work in a team where clinical psychologists and child psychotherapists work jointly on assessments' (Trainee male CPT from Southern England).

The involvement of the professional network surrounding the child was often linked with a perception that assessments were typically complex in nature. This complexity appeared compounded by many of these children's difficult presentations and histories. One respondent commented, 'the assessments for the looked after or adopted child are always complex, require a high level of skill in devising the formulation and care pathway to deliver a target service to the child' (Qualified female CPT from Southern England), thus highlighting the burden this sometimes placed on the therapist and the skills needed when assessing this group.

3.4.5 Direct psychotherapy with looked after and adopted children

Of respondents conducting direct work with children, they reported that a fairly large proportion of those making up their caseloads were looked after or adopted, with a mean of 46.4% (n=167, 10 missing responses). However, there was quite a wide range of variation from this (SD=34).

Table 4 shows a breakdown of the therapeutic work conducted. Most psychotherapy was undertaken with children aged 6-10 (69.8%) and 11-15 years (68.8%), although over half of respondents were working with ages 16+ as well (53.5%). Very young children, age five and under, were also being seen, although to a lesser extent (43.3%). Respondents were asked to select up to five of the most common presenting problems of these children in psychotherapy. A range of problems were selected, perhaps indicating the diversity of difficulties amongst this group. Attachment related problems (72.1%) and impact of trauma/maltreatment (70.2%) were most common, while conduct disorders (57.7%) and risk of placement breakdown (56.3%) also rated highly. 'Previous treatments have been unsuccessful' was selected by 15.8% of respondents as a reason for referral to therapy.

In terms of session format, individual sessions (80.9%) were most commonly practised, although family sessions (62.3%) were also used frequently (this could have referred to either sessions with the foster/adoptive family, or birth family). Group psychotherapy was not conducted frequently (5.6%). The majority of children were seen on a weekly basis (79.5%). Furthermore, long-term work was the most common length, particularly open-ended psychotherapy lasting over a year (75.8%). However, it is interesting that 39.1% of the sample were conducting short-term psychotherapy, given the widespread perception that child psychotherapy is traditionally long-term.

Table 4*Direct psychotherapy with looked after and adopted children*

	N	%
<i>Age range</i>		
0-5 years	93	43.3
6-10 years	150	69.8
11-15 years	148	68.8
16 years and above	115	53.5
<i>Presenting problems</i>		
Attachment related problems	155	72.1
Impact of trauma/maltreatment	151	70.2
Conduct disorders/behavioural problems	124	57.7
Risk of placement breakdown	121	56.3
Offending behaviour	49	22.8
Anxiety disorders	49	22.8
Depression	47	21.9
Self-harm/suicide attempts	43	20
Risk of school exclusion	37	17.2
Previous treatments have been unsuccessful	34	15.8
Sexualised behaviour	9	4.2
Hyperkinetic disorders	8	3.7
Learning disabilities	7	3.3
Autistic spectrum disorders	7	3.3
Eating disorders	1	0.5

Other reason	6	2.8
<hr/>		
<i>Type of psychotherapy</i>		
Brief (usually 1-6 sessions)	45	20.9
Short-term (usually 7-30 sessions)	84	39.1
Open-ended, usually less than 1 year	107	49.8
Open-ended, usually more than 1 year	163	75.8
<hr/>		
<i>Format of sessions</i>		
Individual	174	80.9
Group	12	5.6
Family based	134	62.3
Other (mainly work with foster carers, consultation etc)	55	25.6
<hr/>		
<i>Frequency of sessions</i>		
Less than once a week	31	14.4
Once a week	171	79.5
More than once a week	74	34.4
<hr/>		

The qualitative analysis provided greater detail about respondents' views on their direct work. Respondents frequently commented that these children typically present with a complex combination of problems and co-morbidity of symptoms. However, as the quantitative analysis showed, most comments focused on attachment difficulties, and the impact of maltreatment: 'the level of difficulty which these children present with as a consequence of early neglect and abuse takes a great deal of time to shift.' (Qualified female CPT from London). When respondents spoke about these children's complex presentations, they often linked it to difficulties in engaging them in therapy. One respondent commented, 'often it is offered for children who are extremely 'hard to reach' or highly defended, and they can test the therapist's capacity for fidelity in the face of intense projections.' (Qualified male CPT

from London). These children were commonly perceived as testing the limits of the therapists' resilience and ability to form a workable therapeutic relationship with them. Some respondents then related this to the skills needed by the therapist to tolerate these disturbing and erratic behaviours, 'the therapist...should through their personal analysis be more psychologically robust, as such children are more likely to be highly mistrustful, and testing of boundaries' (Qualified male CPT from London). Despite possessing these skills, some respondents felt such difficult work could impact negatively on the therapist themselves. One respondent highlighted the feelings it may arouse in the therapist,

It is difficult and painful for child and psychotherapist. It can evoke anger, outrage and upset for the psychotherapist working with neglected and abused children...for the child, it can be heart-breaking to let go of psychological defences that once seemed effective and become aware of what they have missed out on in their birth family...that is what makes the work so hard.
(Qualified female CPT from London)

Despite these difficulties, several respondents perceived the therapeutic setting as an appropriate environment for addressing these children's problems. One respondent commented, 'they respond to the boundaried way we work' (Qualified female CPT from Eastern England). They felt the emphasis on a safe, reliable, predictable setting lent itself to these children's need for consistency. However, the perceived level of disturbance presented by these children led respondents to comment on what they believed to be the necessary format of sessions, and length of therapy. Many respondents felt that a minimum of weekly sessions was necessary to build a transference relationship. There was even concern amongst a minority of respondent that some of the most disturbed children 'cannot be treated safely or effectively on once weekly work' (Qualified female CPT from Southern England), with more frequent, intensive work required in these cases. Unfortunately, there were reservations amongst these respondents that they were able to offer this level of input,

I would want to be able to offer a more substantial intervention to looked after children...however the CAMHS only supports short term minimal

psychotherapeutic interventions. What I am able to do I feel is minimal and inadequate. (Qualified female CPT from Eastern England)

It was clear that psychotherapy was viewed as a limited resource, mainly due to time constraints, service resources, or remit limitations. The quote above demonstrates the impact this way of working had on the respondent themselves, who wanted to offer long-term work but was unable to. Relatedly, one respondent commented that although they felt their service would embrace the idea of more frequent sessions, the current state of the research evidence base for psychotherapeutic work with these children precluded this from happening,

I feel that this could be acceptable to the CAMHS in which I work as long as it is backed up by evidence which is supported by NICE [National Institute for Health and Care Excellence]. Unfortunately, without this, intensive work is unlikely to be accepted as credible and a section of our most vulnerable children will not be treated. (Qualified female CPT from Southern England)

The length of therapy was also perceived as vitally important. Supporting the quantitative findings, respondents felt that long-term, open-ended therapy was often needed. One respondent commented, 'the work is particularly challenging on account of their often entrenched resistance to emotional engagement. For this reason it needs to be long-term work' (Qualified female CPT from London). There was an emphasis on adopting a very gradual approach to the developing relationship, going at the child's pace. Taking this one step further, some respondents felt that brief psychotherapy was unsuitable for some children; one respondent remarked that short-term therapy, 'only replicates the child's experience of being left, and the feeling of being 'too much' for anyone' (Qualified female CPT from Eastern England), demonstrating her perception that brief therapy could even be detrimental for them.

Other occasions when child psychotherapy might be unsuitable for these children were also discussed. Mainly this appeared to be for those lacking stability in their lives, for example, in unstable placements or going through court proceedings. The need for child psychotherapists, and other professionals, to be realistic about what could be achieved in therapy, was also emphasised by a few respondents, 'I am concerned that there are often explicit or implicit aims of therapy (usually

requested by allied professionals such as social workers) that are unrealistic given some children's histories' (Qualified male CPT from Northern England). Again, this perception appeared to be based on the depths of these children's problems.

Several respondents felt that child psychotherapy was often chosen as a 'last resort' option when other approaches have failed. This perhaps supports the quantitative data, in which 15.8% of respondents stated this approach was chosen because previous treatments were unsuccessful. This was viewed negatively by some respondents, in that child psychotherapy was not given the recognition it deserved compared to other treatments. However, for other respondents there was some positivity behind this statement, for example one commented, 'Most have been through every other intervention available. It is increasingly recognised that the complexity of their difficulties require more intensive treatment.' (Qualified female CPT from Wales), demonstrating her perception that psychotherapy was a suitable treatment for the depths of many of these children's problems.

3.4.5.1 What makes child psychotherapy unique as an intervention for looked after and adopted children?

Respondents were asked what they thought the unique contribution that psychotherapy had to make to these children was. This brought up a wealth of detailed responses; it was evident that most respondents felt that child psychotherapy was an appropriate intervention for addressing these children's mental health difficulties.

Many respondents spoke about the uniqueness of the psychoanalytic approach. The relational approach adopted by this treatment, with the transference relationship being the mechanism of change, was viewed as particularly pertinent for looked after and adopted children because of the chance to build up a trusting relationship with a benign adult figure, which may have been missing from their lives previously. Some respondents contrasted this to other treatment approaches in emphasising the suitability of child psychotherapy for these children, for example one respondent remarked, 'despite other treatment methodologies being robust e.g. CBT [Cognitive Behavioural Therapy] is well researched, they are often unable to provide an emotional connection to allow the child to process their traumatic experiences and develop the beginning of a trusting relationship with an adult' (Qualified female

CPT from Southern England). Additionally, the child psychotherapist was viewed as providing a containing function for these children, who perhaps had never experienced containment before, 'it offers containment over time for primitive feelings relating to early trauma, enabling the child to gradually locate themselves in their own history' (Qualified female CPT from the Midlands).

The focus on unconscious ways of relating was also seen as appropriate for these children, who may struggle to verbalise their thoughts and feelings. One respondent commented that in comparison to other treatments, child psychotherapy 'doesn't rely on verbal communications' (Trainee female CPT from Scotland). This was often associated with the perceived need for gradual, long-term work, for children's difficulties to be explored at their own pace; emphasised as an approach unique to this treatment, 'the opportunity to speak confidentially (within limits) at their own pace and to share those thoughts that they choose to (i.e., not be asked questions)' (Trainee female CPT from London).

The characteristics of the therapist were also viewed as making this approach suitable, with particular emphasis on the therapist being non-judgemental, consistent, and taking a flexible and adaptive approach to the child's needs. The therapist's training and personal analysis was furthermore viewed as a key component, for example, several respondents spoke about child psychotherapists' training in children's emotional development; this developmental approach and child observation skills allowed them to pay 'careful attention to the smallest detail' (Qualified female CPT from London). Linking to the difficulties these children may present with in therapy, the therapists' own personal analysis was discussed in terms of making them more robust and resilient, able to tolerate and bear the child's projections. In general child psychotherapists were perceived as being able to work with the disturbing and extreme behaviours that some of these children present with, 'ability to work with, manage and understand disturbance...usually recommended when there is complexity like trauma, sexual abuse, attachment difficulties' (Qualified female CPT from the Midlands). One participant commented that child psychotherapists were 'often seen as only clinicians who can engage such patients' (Qualified female CPT from London), thus contrasting their perceived capacity to engage these children with that of other professionals.

Finally, the intensity and depth of the intervention was also spoken about as making child psychotherapy unique. Many respondents commented that this

approach worked at making deep seated changes, which were often needed by these most vulnerable children. Again, this was contrasted to other treatments, with one respondent commenting that child psychotherapy, 'facilitate[s] lasting change that other treatment models do not' (Qualified female CPT from the Midlands) while another stated that it, 'reaches the parts that most other therapies do not seek to address' (Qualified female CPT from Southern England). These 'parts' were characterised as internal changes in the children, 'it is a treatment that brings about internal changes and not just a reduction in symptoms' (Qualified female CPT from Southern England). This included a re-working of disrupted attachment patterns, and an opportunity to change their ways of relating to others.

3.4.6 Work with foster carers and adoptive parents

Work with foster carers and adoptive parents also comprised a large proportion of respondents' work in relation to these children. Table 5 shows a breakdown of this work. Over two thirds of respondents were undertaking direct work with foster carers / adoptive parents alongside individual psychotherapy with the child (72.1%). However, over half were also conducting standalone work (60.9%), and / or consultation work with them (60%). Group work was also being conducted, however this was much less frequently (13.5%); suggesting that the majority of work with foster carers / adoptive parents is on an individual or couple basis.

Table 5*Work with foster carers/adoptive parents*

	N	%
Direct work with foster carers/adoptive parents alongside individual psychotherapy with the child	155	72.1
Direct work with foster carers/adoptive parents not alongside individual psychotherapy with the child	131	60.9
Consultation	129	60
Training	41	19.1
Direct work with foster carers/adoptive parents in groups	29	13.5
Other type of work	16	7.4
Not undertaking work with foster carers/adoptive parents	13	6
Not applicable	26	12.1
Missing	2	0.9

The qualitative data clearly showed the importance many respondents placed on this type of work. One respondent commented, 'I think this is at least as important and possibly more crucial than work with the child' (Qualified female CPT from Southern England), demonstrating a perception that, in contrast to the typical perception of child psychotherapy being primarily about individual therapy, work with carers could sometimes be *more* important than this. However, it was equally apparent that many child psychotherapists felt there is inadequate support available to foster carers and adoptive parents. Psychotherapeutic work with carers was perceived as being undervalued by services or constrained by resource limitations,

I find it is an ongoing struggle to promote this work in CAMHS as being essential in supporting any therapeutic work with child / young person
(Qualified female CPT from Yorkshire)

There was a sense amongst respondents that in many services, more weight was given to a child psychotherapist's direct work with these children, rather than the family around the child. Many respondents perceived that this could lead to carers feeling overwhelmed and unable to cope with the child's behaviour.

The focus of work with foster carers and adoptive parents mainly centred on helping them to understand 'what the child is communicating through their behaviour' (Qualified female CPT from the Midlands). Psychoanalytic concepts were used to frame this understanding, such as helping carers to learn about unconscious processes and withstand the child's projections, as well as providing a general understanding of attachment and the impact of trauma. Several respondents mentioned that this work aimed to strengthen the connection or bond between carer and child. Furthermore, this was viewed as a space to think about the impact of this work on the carers, the painful feelings that may be aroused in the face of seeming rejection by the child, and the ways in which their own previous experiences may affect their relationship with the child,

Crucial to contain anxieties and provide a supportive space for them to air their concerns and the emotional toll it takes caring for these children
(Qualified female CPT from London)

As with other types of work, adopting a flexible approach depending on the needs of the family was apparent; one respondent remarked, 'I use varied approaches according to need' (Qualified female CPT from Southern England). The qualitative material supported the quantitative data in that a range of work was being conducted with carers, from 'holding' sessions prior to therapy with the child commencing, to direct work alongside therapy with the child, to standalone work with carers,

I am likely to work in this way rather than directly with the child for quite some time to stabilise the placement before considering individual work. Often the therapeutic need can be met with this approach, and direct work is not necessary (Qualified female CPT from the Midlands)

This quote demonstrates a model of working in which work with foster carers precedes a recommendation for individual therapy; some respondents spoke about hoping to provide a more ordinary experience for the child, in which they did not have to attend therapy.

Interestingly, while the quantitative data revealed that group work with carers was undertaken less frequently, several qualitative comments focused on this area of practice. These respondents felt that this format was an effective way of working with carers. Several respondents mentioned that their service was currently setting up groups for carers.

3.4.7 Consultation work

Consultancy work with professionals was also conducted by most respondents. This includes commissioned consultations, as well as informal consultancy work. Social care professionals formed the bulk of child psychotherapists' consultations (66%), followed by other mental health professionals (56.3%) and educational professionals (56.3%) (see Table 6).

Table 6

Professionals consulted with regarding looked after and adopted children

	N	%
Social care professionals	142	66
Other mental health professionals	121	56.3
Educational professionals/early years services	121	56.3
Trainee or qualified child psychotherapists	75	34.9
Other professionals	39	18.1
Not undertaking consultancy work	23	10.7
Not applicable	26	12.1

Missing

1

0.5

The qualitative data supported the quantitative material in that there were a range of professionals respondents were providing consultation for. Furthermore, a variety of approaches were used: both group and individual consultations; one off consultations advising about a specific case; and ongoing work such as regular consultation slots and attending multi-agency meetings. The contribution that respondents felt they were making during these meetings was apparent, for example one respondent said they were 'providing the perspective of thinking about a child's internal world which is often not spoken about' (Qualified female CPT from Eastern England). This focus on the child's internal world and unconscious ways of relating was contrasted to what they perceived is typically spoken about in network meetings, which is the child's actions or behaviour.

Respondents also spoke about the purpose of their consultation work. In many ways this paralleled the work with foster carers and could be divided into two broad categories: providing an understanding of the child's behaviour; and providing support to the network around the child. With regards to the child's behaviour, in a similar way to work with foster carers, this focused on 'helping those working directly with the young person to better understand their puzzling or unsettling behaviours...using a psychoanalytic perspective' (Qualified female CPT from London). Common themes included providing insight about attachment difficulties and the impact of trauma, for example, one respondent commented, 'providing a framework with which to try to make sense of children's behaviour e.g. stealing in the context of an early experience of neglect' (Qualified female CPT from Southern England). Additional areas included thinking about the child's emotional state and mental health needs, as well as advising regarding care planning, contact with birth family, and at times of transition such as changes of placement.

Providing support to the professional network itself was viewed as a crucial aspect of respondents' consultations. Many spoke about consultations being a space to encourage reflective practice, for the network to consider the effects of working with these children on themselves. Understanding and reflecting on network dynamics, for example 'splits in the network' (Qualified female CPT from the

Midlands), was also viewed as important to secure stability amongst professionals, and in ensuring they did not re-enact the child's previous experiences with their birth family. One respondent remarked, 'To understand how dynamics within the network system...often reflects something of the child's experience and that of the birth, fostered families' (Trainee female CPT from London). Linked to this, some respondents spoke about the child psychotherapist providing a containing function for the network, in a similar but different way to the containing function they previously spoke about providing for the child. One respondent commented their role was around, 'containing the anxiety of other professionals, sometimes under a great deal of pressure to 'fix' the child, and promoting the idea that the priority is for the child to feel safely and securely placed' (Qualified female CPT from the Midlands). This quote demonstrates the perception that there are high levels of anxiety within professional networks around these children, and their perceived role in recognising and managing this anxiety.

There was a general feeling that working with the professional network was a vital aspect of a child psychotherapists' work regarding looked after and adopted children. One respondent remarked that this work 'distinguishes the work from child psychotherapy with children who live in birth families' (Qualified female CPT from London). Another commented that they frequently engaged in consultation with the network, 'where the mobilisation of the network is likely to be more valuable than direct work with the family' (Qualified female CPT from Southern England). This demonstrates a perception that consultations were often seen as equally, or sometimes even more valuable than, direct work with the child. This viewpoint appeared to be linked to perceived problems within the network itself, with the dynamics impacting on the child's welfare, as discussed above. However, there was concern that this aspect of their work, similarly to work with foster carers and adoptive parents, was not always given the recognition needed compared to direct therapeutic work. This was despite the fact some respondents thought their input was valued by other professionals, 'consultations are valued by social workers even when there is no direct work, but this can be harder for commissioners to understand' (Qualified female CPT from London), again linking it to service remit and resource limitations.

3.4.8 Supervision

Table 7 shows the professionals whom respondents were conducting supervision with around looked after and adopted children. Supervision of other child psychotherapists was the most common (34.9%), however respondents were also conducting this work with other professionals; most frequently, other mental health professionals (33%).

Respondents were not asked to provide any further details on their supervisory work.

Table 7

Professionals who respondents provided supervision for

	N	%
Child psychotherapists	73	34
Other mental health professionals	71	33
Social care professionals	42	19.5
Foster carers/adoptive parents	27	12.6
Educational professionals/early years services	24	11.2
Other professionals	11	5.1
Not undertaking supervision	75	34.9
Not applicable	26	12.1
Missing	2	0.9

3.4.9 Teaching and training

Teaching and training were most commonly undertaken with social care professionals (21.4%), although there was only a marginal difference in frequencies of teaching / training amongst other professionals (see Table 8). Respondents were asked to comment on the focus of their teaching / training. Of the 68 people who

commented, the most common topics were: attachment (n=28); effects of trauma and abuse (n=14), child development (n=12); the child psychotherapeutic approach (n=11); behaviour management / understanding the child (n=11) (respondents could fall into more than one category).

Table 8

Professionals who respondents provided teaching / training for

	N	%
Social care professionals	46	21.4
Other mental health professionals	39	18.1
Foster carers/adoptive parents	38	17.7
Trainee child psychotherapists	36	16.7
Educational professionals/early years services	31	14.4
Qualified child psychotherapists	15	7
Other professionals	8	3.7
Not undertaking teaching/training	101	47
Not applicable	26	12.1
Missing	6	2.8

3.4.10 Research and evaluation

Research and evaluation were the least common activities undertaken by respondents working with looked after and adopted children.

The most frequent type of evaluation was routine outcome monitoring (20% of 56 sample; see Table 9). 12 respondents gave further information on this. The most frequent measures used were: the Strengths and Difficulties Questionnaire (Goodman, 1997) (n=10); goal-based outcome measures (Law, 2013) (n=7); the Revised Children's Anxiety and Depression Scale (Chorpita et al., 2015) (n=6); and

the Children's Global Assessment Scale (Shaffer et al., 1983) (n=4). These were typically collected at the outset of therapy and then at six monthly intervals until therapy terminated.

Only nine respondents gave comments on their research, which were mostly unpublished doctoral theses or research in the process of being published.

Table 9

Research and evaluation undertaken by respondents

	N	%
Not undertaking research and evaluation	133	61.9
Not applicable	26	12.1
<i>Evaluation methods used (n=56)</i>		
Not undertaking evaluation methods	1	0.5
Routine outcome monitoring	43	20
Service audit	30	14
Qualitative feedback	28	13
Other type of research evaluation	12	5.6
Other	4	1.9

3.4.11 Patterns of working between qualified and trainee child psychotherapists

The working patterns of qualified child psychotherapists were compared to trainee child psychotherapists (see Table 10). Several significant differences emerged. The percentage of qualified child psychotherapists working in the following areas was significantly higher than trainee child psychotherapists: work with foster carers / adoptive parents (Fisher's exact, $p < 0.05$), consultations (Fisher's exact, $p < 0.005$),

supervision ($\chi^2 (1, 186) = 53.22, p < 0.0005$), and teaching and training ($\chi^2 (1, 183) = 22.79, p < 0.0005$).

Furthermore, significantly more qualified child psychotherapists were working with looked after and adopted children age 16+ ($\chi^2 (1, 176) = 9.53, p < 0.005$), and conducting brief ($\chi^2 (1, 176) = 6.17, p < 0.05$) and short-term therapy ($\chi^2 (1, 176) = 17.81, p < 0.005$). More qualified child psychotherapists were conducting family based therapy than trainees ($\chi^2 (1, 176) = 20.73, p < 0.005$). However, significantly more trainee child psychotherapists were doing long-term psychotherapy, usually lasting over a year in length (Fisher's exact, $p < 0.05$), and meeting looked after and adopted children for greater than once weekly sessions ($\chi^2 (1, 176) = 41.89, p < 0.005$).

Table 10*Working patterns of qualified versus trainee child psychotherapists*

	N	%	N	%
	<i>Trainee (N=39)</i>		<i>Qualified (N=149)</i>	
Assessment	37	94.9	142	95.3
Direct psychotherapy	39	100	137	91.9
Work with foster/adoptive carers	32	82	141**	95.9
Consultation work	28	71.8	137*	92.6
Supervision	3*	7.9	108*	73
Teaching / training	4*	10.5	78***	53.8
Research / evaluation	9	23.1	47	31.5
<i>Direct psychotherapy work</i>	<i>N=39</i>		<i>N=137</i>	
Age range 0-5	20	51.2	73	53.3
Age range 6-10	31	79.5	119	86.9
Age range 11-15	29	74.4	119	86.9
Age range 16+	17	43.6	97	70.8
Individual work	37	94.9	136	99.3
Group work	2	5.1	10	7.3
Family work	19	48.7	115	83.9
Other work	7	17.9	48	35
Brief psychotherapy (1-6)	4	10.3	41	29.9

Short-term psychotherapy (7-30)	7	17.9	77	56.2
Open-ended (< 1 year)	22	56.4	85	62
Open-ended (>1 year)	39	100	123	89.8
Less than once a week	4	10.3	27	19.7
Once a week	36	92.3	134	97.8
More than once a week	34	87.2	40	29.2

*1 missing

**2 missing

***4 missing

3.5 Discussion

The findings of this study demonstrate that the majority of UK child psychotherapists surveyed were doing some form of work with looked after and adopted children, and their professional network. Although the findings should be taken with caution, given the limitations of the sample (see section 3.5.1), a substantial proportion of ACP members were conducting work with these children and their professional network. Furthermore, comparison of the survey sample to the demographics of the general ACP membership suggests those surveyed were fairly representative of the wider membership.

This study provides some insight into the range of settings that child psychotherapists were working in, both generally and specifically with looked after and adopted children. Although the majority worked in NHS CAMH services, as the child psychotherapist is traditionally perceived to, a proportion were also working in settings such as private practice, and targeted LAC services within CAMHS and social services. This wide range of contexts has been found in previous surveys (Sherwin-White et al., 2003) and perhaps demonstrates that child psychotherapists continue to work in a diverse range of settings; consistently more diverse than it is sometimes recognised as.

This study also demonstrates the wide range of activities conducted by child psychotherapists regarding these children. The most common were assessment, direct psychotherapy, work with foster carers and adoptive parents, and consultation with the professional network. While supervision was conducted by just over half of respondents, teaching / training, and research / evaluation were conducted less frequently. These findings provide some support for the clinical literature regarding child psychotherapy with these children, which has shown that, despite previously not being recommended, psychotherapy is being undertaken with this vulnerable group (e.g. Boston & Szur, 1983; Briggs, 2015; Hughes, 1999; Hunter, 2001). Furthermore, this study builds on the previous literature by demonstrating the breadth of work conducted with these children across a national sample of UK child psychotherapists (Kam, 2004; Petit & Midgley, 2008; Sherwin-White et al., 2003). Research and evaluation were the least common activities undertaken by respondents; this suggests an area of development for child psychotherapy services. This is particularly relevant considering the literature reviewed in Chapter 2 of this thesis, for which the vast majority comprised clinical material, rather than empirical research. Given the increasing emphasis on using evidence-based treatments and practice within clinical practice, there is a need for the child psychotherapy profession to contribute to research and evaluation of their own activities.

In terms of respondents' direct work with these children, the most common format of sessions were once weekly and individually. This supports a previous national audit of child psychotherapists about their work with children referred for therapy, which found that respondents reported weekly sessions as the most common (Rance, 2003). It was clear from respondents' reported ways of working, and their views expressed through the responses to the open-ended text sections of the survey, that long-term, and often intensive, psychotherapy was felt to be needed with these children. Previous literature has also highlighted that children with complex difficulties are perceived by child psychotherapists to need more intensive psychotherapy (Green, 2009). However, to a lesser extent, brief and short-term psychotherapy was also being conducted by respondents, particularly qualified child psychotherapists. Traditionally, child psychotherapy has been viewed as a long-term treatment approach (Petit & Midgley, 2008), therefore it is interesting that many respondents are working in more time-limited and brief ways. In some cases, this may reflect resource or remit limitations of services, which was raised by some

respondents as restraining their preferred ways of working with these children. There was a common dilemma about offering therapy to children when the service was not able to offer the level of therapeutic input perceived as necessary. Concerns were raised that for the most disturbed children, even a minimum of weekly sessions was not enough to treat the depths of their problems, with more frequent, intensive work felt to be required in these cases. Relatedly, some respondents felt that short-term psychotherapy could be detrimental for children with experiences of loss and abandonment, replicating their experiences of being left. Respondents also spoke about other instances in which they perceived that therapy may be unsuitable for these children. This included children who were lacking stability in their lives, for example those just entering the care system, going through court proceedings, or in unstable placements.

Respondents' discussion of these children's presenting problems suggested a complex combination of difficulties. This has been noted by previous literature; Midgley and Kennedy's (2011) review of psychodynamic treatments for children and adolescents reported that children who have experienced trauma / maltreatment are a diagnostically diverse group, while DeJong (2010) states that this complexity often makes categorisation into clinical mental health diagnoses problematic. The most frequently rated problems for children in this survey were attachment related issues and the impact of trauma or maltreatment, and these children were often perceived as being highly mistrustful and testing the boundaries of the therapeutic relationship. This lends support to recent research around the role of attachment and early adversity in the development of epistemic trust, i.e. the capacity to trust others as sources of knowledge concerning the interpersonal world, with survey respondents highlighting the perceived levels of epistemic mistrust and epistemic hypervigilance amongst this group of traumatised children (see Fonagy et al., 2015; Fonagy et al., 2016). Hence, the very children that may benefit the most from establishing such a relationship, seem to have marked problems in this area.

Respondents were also asked about what they thought the unique contribution that child psychotherapy could make to looked after and adopted children was. Many people felt that child psychotherapy was an appropriate intervention for many of these children, despite perceived difficulties that may emerge during therapy. Respondents particularly highlighted the emphasis on the relational approach, the characteristics of the therapist, and the intensity and depth

of the intervention, as being suitable. These characteristics were often contrasted to other treatment approaches.

A particularly noteworthy finding is that direct therapy was viewed as just one aspect of a child psychotherapist's role with these children (which may be seen as the 'traditional' role of a child psychotherapist). There was an emphasis on their role within the professional network, including work with carers and consultations with professionals. Network working permeated many aspects of child psychotherapists' work, for example, assessments relied heavily on working with the network. This finding perhaps indicates the way in which actual practice seems to have adapted to the nature of these children's problems, and furthermore supports the growing recognition amongst therapeutic interventions of the importance of network working, particularly in complex cases (e.g. Bevington et al., 2013; Fonagy et al., 2015). The qualitative analysis showed that although these aspects were viewed as vitally important, they were also perceived as being under-resourced and sometimes under-valued by services in comparison to therapy.

There were also differences between trainee and qualified child psychotherapists' ways of working with these children. More qualified child psychotherapists were conducting more work with the professional network than trainees, including work with carers. This could conceivably be explained by both levels of experience and training requirements, for example qualified child psychotherapists may often support the individual work of trainees by conducting work with carers themselves. Furthermore, significantly more trainees were conducting long-term psychotherapy and meeting children for greater than once weekly sessions. Again, this could possibly be due to training requirements, with trainees required to conduct both long-term work and frequent therapy sessions.

3.5.1 Limitations

The survey comprised responses from a quarter of the ACP membership; while this is not necessarily a low response rate when compared to a previous survey of the profession (Rance, 2003, who had 213 responses), it does mean the working patterns of the majority of UK child psychotherapists were unaccounted for. It is conceivable that those who completed the survey did so because they were

interested in this area of practice and were working with looked after and adopted children. In turn this may have reflected the high proportion of respondents working with these children. However, it is worth noting that survey respondents' characteristics were quite similar to those of the general ACP membership.

Furthermore, the quantitative sections of the survey used pre-defined categories to categorise responses. Although the response options were piloted, and all questions included an 'other' category which respondents could select if none of the others were applicable, these pre-defined categories may have meant that some work was missed. Respondents were given the opportunity to expand on their answers with comments boxes and qualitative questions, however as it was a survey rather than interviews, their responses may lack a certain richness and depth. On the positive side, most respondents provided detailed responses to the qualitative questions. While this meant some interesting perspectives were raised, these were not able to be explored further, meaning there is an opportunity to build on this.

3.5.2 Conclusion and implications for the PhD

This study's findings demonstrate that most child psychotherapists surveyed were doing work with looked after and adopted children in some capacity, and this spanned a wide range of activities. Many respondents placed emphasis on work with the professional network and foster carers / adoptive parents, as well as seeing these as an area of development for child psychotherapy services. This is an area worthy of further exploration for study.

4 Study 2: The child psychotherapists' role as consultant to the professional network around children in local authority care

4.1 Introduction

The previous chapter detailed the findings of study 1, a survey of UK child psychotherapists about the nature and provision of psychoanalytic models of intervention for looked after and adopted children. A prominent finding from this study was the emphasis that respondents placed on their work beyond individual therapy with children in local authority care, i.e. work with foster carers and the professional network around these children, as well as seeing this as an area of development for child psychotherapy services. Building on this finding, this chapter describes the second study of the thesis, which explores the child psychotherapists' role as consultant to the professional network and foster carers⁴, using qualitative interviews with child psychotherapists who specialise in this area of practice.

This chapter begins with an overview of the literature on psychoanalytic approaches to thinking about organisations. This theoretical framework is relevant to how psychoanalytic child psychotherapists, working as consultants within the children in local authority care field, may frame their understanding of professionals' and foster carers' responses to managing anxieties and feelings. This is followed by a review of the existing literature on child psychotherapists' work as consultant to the professional network and foster carers.

⁴ While study 1 included child psychotherapists' work with adopted children and adoptive parents, this study solely focuses on work with the professional network around children in local authority care, and work with foster carers. The purpose of this was to narrow the focus of the research. Whilst acknowledging that children in local authority care and adopted children likely share some similarities in terms of their experiences, there are different legal systems in place around these children. Moving from foster care to adoption also presents its own challenges and opportunities (Selwyn, 2017). Therefore, the remainder of the PhD research focuses solely on children in local authority care.

4.1.1 *Psychoanalytic thinking about organisations*

Psychoanalytic approaches to thinking about organisations has a long history (e.g. Freud, 1921). In 1955, Jaques' proposed that social systems can unconsciously act in ways that defend against paranoid and depressive anxiety; this has since been referred to as the 'social defence theory' (see Long, 2006). This approach provides a framework for understanding how practitioners in healthcare settings, and related fields such as social work, manage emotions induced by the nature of the work, and the impact the organisation can have on this (Hinshelwood & Skogstad, 2000; Obholzer & Roberts, 1994). This approach proposes that if these feelings are not managed appropriately, they can become unbearable and extend beyond the individual worker into the organisation itself (Rustin, 2003).

Menzies-Lyth's (1960) definitive study of a nursing service in a general hospital built on Jaques' work, exploring the reasons underlying high rates of drop out from nursing training. Menzies-Lyth proposed that nursing staff developed a variety of techniques to defend against the anxiety inherent in a role with responsibility for seriously ill and dying patients, arguing that the intimacies of the nursing role led to the emergence of primitive sexual and death conflicts. The defensive techniques she identified included the depersonalisation of patients, limiting contact in the nurse-patient relationship, denial of feelings, splits amongst team members – for example junior staff feeling that senior staff were unsupportive of them – and reducing a sense of responsibility by including numerous staff members in decision-making. Menzies-Lyth's research was influential in proposing how social structures reinforce practitioners' defences against primitive anxieties generated by the work, and ultimately disrupt the task of the organisation.

More recently, Hinshelwood and Skogstad (2000) extended the work of Menzies-Lyth by collating observations of various defensive techniques in healthcare settings, both in mental health and general healthcare. Their 'anxiety-culture-defence model' (p.16) proposes that the anxieties aroused in individual workers in these settings develops a collective defence within the organisation, and thus becomes part of the culture of the organisation itself. Relatedly, Obholzer and Roberts' (1994) collection of work about consultant led groups at the Tavistock Institute of Human Relations, aiming to tackle organisational problems in healthcare environments,

highlights the role of external consultants in helping staff to overcome these unconscious 'blocks' to their working.

Bion's (1961) theory of groups is another psychoanalytic perspective that can be applied to organisational dynamics. Bion's theory centres on the unconscious dynamics that occur within groups, particularly defences that groups use to manage anxiety. Bion hypothesised that in every group, there is the 'work group' (the aspects that function effectively on the group task), and the 'basic assumption group' (unconscious patterns of behaviour, operating at a more primitive level, that interfere with the group functioning on its task). Bion identified three basic assumptions: dependency; fight-flight, and pairing. In dependency, group members share unconscious feelings of helplessness and inadequacy, depending on an external object to relieve their anxiety. In fight-flight, the group acts in survival mode as if from an external threat, characterised by either hostility or avoidance of the task. In pairing, there is the unconscious assumption that the group will function more effectively if it splits into pairs, however this can ultimately lead to increased conflict amongst group members. When the group is operating in basic assumption mode, it ceases to function effectively on its purpose.

Psychoanalytic frameworks to thinking about organisational dynamics have been applied to contexts outside of healthcare organisations, including social work; a profession commonly at risk of stress and burnout (Lloyd et al., 2002). Contributing factors to stress and burnout in social work include a perceived lack of autonomy, frequent changes in organisational structure, and a socio-political climate dominated by increasing target and audit cultures, a preoccupation with risk, and intense public scrutiny (Broadhurst et al., 2010; Hingley-Jones & Ruch, 2016; Lloyd et al., 2002; Morrison, 1990). Several studies and papers have described techniques used by social work practitioners – particularly within child protection – to defend against anxieties stimulated by the task of the organisation (e.g. Cooper, 2010; Ferguson, 2018; Lees et al., 2013; Rustin, 2005; Whittaker, 2014). Rustin's (2005) analysis of the Victoria Climbié enquiry aimed to understand why professionals failed to act despite evidence of Victoria's abuse. Rustin compares the functioning of the organisations surrounding Victoria Climbié to that of a borderline patient; organisations who functioned as a means of protecting themselves against the appalling psychological impact that a recognition of reality would engender. In another analytical paper, Lees et al. (2013) describe the challenges of working with

risk and uncertainty inherent in child protection work, including the burden of responsibility of decision-making in uncertain circumstances, while managing anxiety around accusations of malpractice. Defensive structures identified include prescriptive and bureaucratic management procedures, the use of ritual tasks ('box-ticking') and checking and counterchecking before deciding on action. These structures, while designed to overcome risk and uncertainty, instead act to increase anxiety and divert social workers away from spending time with service users – paralleling Menzies-Lyth's assertion of the 'splitting up' of the nurse-patient relationship (Lees et al., 2013). The Munro review of child protection noted that this climate of managerialism greatly impacted on social workers' ability to use professional judgement, in turn leading to lowered job satisfaction and increased staff turnover (Department for Education, 2011). The Munro review recommended a shift away from prescriptive management procedures; thus, demanding a need for more helpful means of managing task-related anxieties (Lees et al., 2013).

Within this context, it follows that if experiences and anxieties can be thought about – rather than suppressed – practitioners can make sense of them and tolerate the feelings and uncertainties generated in these working environments (Menzies-Lyth, 1960; O'Sullivan, 2019). The Munro review highlighted the importance of spaces for social workers to consider the emotional aspects of their role (Department for Education, 2011). This can be provided through several means, including supervision, reflective practice environments, and organisational structures that help practitioners to constructively manage and contain emotions (Dartington, 2010; Obholzer & Roberts, 1994; Ruch, 2007). Within the field of children in local authority care, the NICE and SCIE guidance on improving the health and wellbeing of these children, recommended that professionals and foster carers should have access to specialist consultation, delivered by in-house advisors, external consultants, or members of CAMHS (NICE/SCIE, 2010a). One approach to reflective practice and consultation with professionals working with children in local authority care, commonly drawing on the principles outlined above, is offered in the UK by psychoanalytic child psychotherapists.

4.1.2 *Psychoanalytic consultation for professionals working with children in local authority care*

Relatively little has been written about child psychotherapists' consultation work with the professional network around children in local authority care. However, the literature that does exist suggests that child psychotherapists perceive this to be an integral component of their work within this field. Hunter (2001) contends that it is pivotal for child psychotherapists to form strong working relationships with other agencies in the child's network, continually having an awareness of the external environment around the child. One aim of consultation may be to decide whether psychotherapy is a possibility for the child, and the task may then be to prepare the network for undertaking therapy (Rocco-Briggs, 2008; Sprince, 2000; Wakelyn, 2008). However, child psychotherapists may also consider psychoanalytic liaison and consultation with the network as a useful intervention, either instead of, or in addition to therapy (Wakelyn, 2008).

It has been argued that networks around these children have an inclination to repeat aspects of the child's traumatic experiences, often leading to splits and conflict in the network; Wakelyn (2008) links this to Freud's theory of repetition compulsion, in which fragmentation within networks often replicates breakdowns within families. Several child psychotherapists have noted the therapists' role in providing consultation to overcome such conflicts (Emanuel, 2002; Granville & Langton, 2002; Hunter, 2001; Rocco-Briggs, 2008; Sprince, 2000). Emanuel (2002) describes the setting up of a therapeutic service in a children's social services department; the initial remit was to provide individual therapy as a priority, with foster carer support and consultation to the professional network as secondary aims. She describes how she changed her approach, after recognising the detrimental impact that the levels of disturbance related to these families had on network professionals and foster carers, often impeding their capacity to think about the child's needs. She argues that within these circumstances the professional network can re-enact the child's projections and defences against anxiety, using the term 'triple deprivation' (first used by Sutton, 1991) to suggest that these children experience three levels of trauma. The first level is the original trauma or abuse experienced, the second is the internal defences impacting on them accessing support from professionals or foster carers, and the third is the deprivation that the organisational system can then put

onto these children. In particular, she describes a kind of ‘paralysis’ in the network, whereby social workers face contradictory impulses that replicate the freezing of children displaying a disorganised attachment response, and lead to cases ‘drifting’ within the system. She argues that a containing structure is needed around social workers and their managers to enable more adaptive coping responses. Relatedly, Boswell and Cudmore (2017)’s analysis of interviews with foster carers, adopters, and social workers of five children transition to adoption identified a ‘blind spot’ amongst the network; concluding that the adults found it very difficult to fully engage with the child’s emotional state during transition. Over the course of the transition, their language gradually became more procedural, with foster carers adopting a more ‘professional’ role, despite feeling the personal loss themselves.

Sprince (2000) describes how psychoanalytic consultancy and the development of a ‘therapeutic network’ around the child can either be provided as an alternative, or a supplement, to individual therapy with the child. She discusses the feelings of envy and rivalry that can be stirred up between teams working within this field; exacerbated by the disturbing projections of children and families into the professionals caring for them. She argues that within this context, the ‘emotional work’ (p. 424) can all be left to the therapist, with little room left for foster carers or professionals, positing child psychotherapists should consider forsaking being the child’s primary transference object, and instead focus on bringing the adults together.

In another clinical paper, Rocco-Briggs (2008) describes her perception that children in local authority care may communicate different aspects of their feelings to different professionals in their network, who may each separately hold pieces of the child’s pain. She perceives that an approach of working with the network gives professionals space to share their experiences of working with a child, in turn preventing them from acting defensively from feelings that are unmanageable. She notes the complex difficulties of achieving this process, perceiving that professionals may commonly locate problems within the child themselves, however she feels that providing space for reflection allows the establishment of an integrated, cohesive network.

Child psychotherapists working in residential settings have also discussed their role in providing consultation to professionals in environments such as specialist schools and therapeutic communities (Cregeen, 2008; Wilson, 2009).

Many of the most well-known residential foster care homes were originally set up and run along psychoanalytic lines, for example the Mulberry Bush School, which was developed from Dockar-Dysdale's work (1968, 1973). Residential staff often endure the transference of children's painful emotions from their birth families, making it a challenging and sometimes overwhelming environment to work in (Cregeen, 2008; Wilson, 2009). Cregeen (2008) describes his experiences of providing consultation to workers in adolescent residential settings, discussing how the internal worlds of the young people create complex dynamics within teams providing care for them, including oscillating between 'group' and 'gang' states of mind (Canham, 2002). He posits that these dynamics may be repeated in the transference relationship with the child psychotherapist, acting as consultant, and that it is the therapists' task to bear this negative transference. Through consultation, he proposes that child psychotherapists can help staff to hold an empathetic view of the children in their care, whilst maintaining a level of separation from them. Cregeen (2008) and Wilson (2009) relate this work to Bion's (1962) concept of containment, arguing that containment is at the heart of work with children and staff in residential settings.

Taken together, whilst the limited existing clinical literature gives some indication of the child psychotherapists' role as consultant to the professional network around children in local authority care, no research has explored this aspect of their practice – including their perceptions and experiences of their role, and what they see as specific to the psychoanalytic approach; particularly given that other models of reflective practice and consultation exist within the social work field (e.g. Schon's (1991) model of reflection-in-action / reflection-on-action; the critical reflection model (Fook & Gardner, 2007); the systemic unit or 'Reclaiming Social Work' model (Cross et al., 2010); and action learning sets (see Abbott & Taylor, 2013).

4.1.3 Psychoanalytic consultation, support, and training for foster carers

Foster carers provide the everyday care for children in local authority care, including emotional support, and this can commonly involve managing very challenging behaviour from the children in their care (Hiller et al., 2020). A research study

comprising focus groups with 21 UK foster carers found that carers consistently reported inadequate training and support to enable them to support the child; this was viewed as a contributing factor to placement breakdowns. The importance of foster carers accessing appropriate training and support, including professional mental health support, has therefore been emphasised (Hiller et al., 2020). As discussed in Chapter 1, many interventions targeting foster carers focus on reducing problem behaviours, which have been criticised for neglecting the importance of building secure and trusting relationships between children and adults (Luke et al., 2014). Interventions which target this have therefore been emphasised, particularly for children with trauma and attachment related problems (Luke et al., 2014; Redfern et al., 2018).

Although most survey respondents in study 1 of this thesis indicated that they were working with foster carers in some capacity, the literature on child psychotherapists' work with foster carers is again limited. Only several clinical papers and book chapters describe psychoanalytic consultation and support for foster carers (e.g. Barratt, 2015; Emanuel, 2002; Hunter, 2001; Rocco-Briggs, 2008; Sprince, 2015). Within this field, Ironside has been most prolific in describing therapeutic support to foster carers (Ironside, 2004; 2009; 2012). Although sharing some commonalities with work with birth parents, Ironside (2009) feels that the unique situation of the foster carer makes the work quite distinct in nature. This is supported by Hunter (2001), who argues that foster carers are in a difficult position, with very little decision-making ability over the children in their care and who may easily bear the brunt of the blame from both children and professionals. Ironside describes supporting foster carers who are 'living a provisional existence' (Ironside, 2004, p. 39), in which they feel trapped in a parenting state contradictory to their hopes for the foster child-parent relationship – for example caught between the torment of living with a destructive child, and the guilty feelings of wishing to part from them. Ironside describes working to help diminish this persecutory experience for them, through thinking about the ways these children may be re-enacting previous experiences, recognising when the child is evacuating intolerable emotions into them, and therefore being able to separate themselves emotionally from the situation. He considers it the role of the child psychotherapist to work together with foster carers in reflecting on the child's emotional difficulties, with the therapist then offering strategies for how the carer could respond. He states that it is the foster

carers' role to be able to maintain a reflective capacity while also being able to contain the child emotionally; but furthermore it is the child psychotherapists' role to contain the foster carer's anxieties (Ironsides, 2004; 2009). Several child psychotherapists have drawn on a mentalizing framework in describing helping foster carers develop capacity to mentalize about their own, and the child's, mental states (Ironsides, 2012; Onions, 2018).

Empirical research exploring child psychotherapists' work with foster carers is limited. Onions (2018) conducted a qualitative research study exploring the embedding of a reflective practice culture with foster carers and birth parents at the residential Mulberry Bush School in Oxfordshire. Interviews were conducted with 11 participants at two timepoints: during the child's first week at school, and 12 months later. At baseline, all participants reported feeling at 'rock bottom', overwhelmed and unable to cope with the child's behaviour; after 12 months' support, 10 of the 11 participants reported feeling less overwhelmed and that their child was easier to parent. This was a small study that focused on foster carers' and parents' experiences of receiving psychotherapeutic support. No research has explored child psychotherapists' perceptions about their role as consultant to foster carers.

In addition to therapeutic support, child psychotherapists can also provide training. It has been noted that traditional foster carer training commonly focuses on strategies for managing the child's behaviour, yet feeling this may not be the most suitable focus for those parenting severely deprived children, who may be unlikely to experience them as coming from a caring place (Barratt, 2015; Sprince, 2015). Furthermore, Barratt (2015) remarks that it is equally important for the foster carer to develop the ability to understand the child's emotions underlying the behaviour. Onions (2018) has also argued that time-limited trainings for foster carers, while imparting important informational and theoretical knowledge, may be insufficient for carers looking after children with complex and challenging emotional difficulties; recommending that longer-term support is additionally provided. In line with these recommendations, Ironsides (2009; 2012) describes the development of a group programme that combines psychoanalytic thinking and infant observation training (Miller et al., 1989). During the eight-week programme, participants are asked to observe the child in their care at a set time each week, paying attention to the thoughts and feelings aroused in them during the observation. Observations are then presented to the group, allowing them space to reflect together, providing insight into

the child's internal world, and gaining support from a mental health professional facilitator and other foster carers.

Although the clinical papers described above provide some indication of child psychotherapists' approach to foster carer training, empirical research is again lacking. Evaluations of mentalization-based group programmes are currently being undertaken (the Reflective Fostering Programme; Midgley et al., 2019), which share some commonalities with the model of training described by Ironside (2012), however no research has explored, or evaluated, psychoanalytic models of consultation, support, and training for foster carers.

Ultimately, although the existing literature gives some indication of the child psychotherapists' role as consultant to both foster carers and the professional network around children in local authority care, no research has explored these aspects of their practice in-depth, particularly how child psychotherapists understand their work with the network. This is pertinent given the recommendation for professionals around children in local authority care to receive specialist support from external agencies, including CAMHS (NICE/SCIE, 2010a), and there is a need to distinguish whether psychoanalytically informed models of consultation offer something distinctive to reflective practice, in comparison to other models, particularly in the social work field.

4.2 Study aims

The aim of this study was to gain an in-depth understanding of the ways in which child psychotherapists work with the professional network around children in local authority care (for example, social care, education, health, and including foster carers). In particular, the study aimed to explore how child psychotherapists understand and experience their work with the network, and what they see as particular to the psychoanalytic approach.

The research question was: how do child psychotherapists understand and experience their work with the professional network around children in local authority care, and what do they see as particular to the psychoanalytic approach?

4.3 Methodology

4.3.1 Research design

This study was a qualitative design, using thematic analysis (Braun & Clarke, 2006) to analyse semi-structured interviews with a sample of child psychotherapists.

4.3.2 Sampling strategy

Potential participants were child psychotherapists who completed the online survey about their work with looked after and adopted children (study 1). Survey respondents were asked to leave their name and email address on completion of the survey if they were interested in taking part in later stages of the research; 135 out of 215 respondents did this. The inclusion criteria for study 2 were survey respondents who had agreed to be contacted and who had indicated in the survey that they worked with the professional network around children in local authority care (including work with foster carers). Respondents who did not work with the professional network and / or foster carers were excluded, as were those who did not provide their contact details on completion of the survey.

From the 116 potential participants that this left, a purposive sampling strategy was then adopted to identify a list of potential interviewees, using criteria identified in study 1 as being common amongst survey respondents. Namely, participants who worked in the three most common workplace settings identified in the survey were selected (generic Child and Adolescent Mental Health Services (CAMHS) teams; private practice; and targeted LAC teams within CAMHS). Furthermore, of participants who worked with foster carers, those who conducted the most common types of work identified in the survey were selected (direct work running parallel to therapy to the child; direct standalone work with carers; consultations with carers). Finally, potential participants were selected to ensure a range of UK locations was covered. Based on these criteria, and ensuring a range of UK locations were included, a list of 15 potential interviewees was drawn up. They were contacted by email with the study information sheet and asked if they were interested in participating. A reminder email was sent to those who did not respond

initially. Nine participants responded expressing an interest, and all nine were interviewed.

4.3.3 Participants

Five participants were female. Two worked in generic CAMHS teams (although one had recently retired); three worked in private practice; and five in specialist CAMHS teams for LAC, adopted children, and/or children in kinship care. Two participants worked for more than one service. Although these services represented the three most common workplace settings amongst survey respondents in study 1, more survey respondents worked in generic CAMHS teams (59.1%), and less worked in specialist LAC services (20%) and private practice (15.8%) than in this study. Amongst interviewees, the mean number of years' experience as a qualified child psychotherapist was 14.4 years (SD=9.9) and ranged from 4 to 32 years. This was similar to survey respondents (mean=11.6 years, SD=8.8), although participants in this study had on average slightly more years of experience. Five participants completed their child psychotherapy training at the Tavistock and Portman NHS Foundation Trust; two at the British Psychotherapy Foundation (BPF); one at the Birmingham Trust for Psychoanalytic Psychotherapy; and one at the Northern School of Child and Adolescent Psychotherapy. In terms of geographical location, four participants worked in London, three in Southern England, two in the Midlands, and one in Northern England (one participant worked in two locations). Again these characteristics followed a similar pattern to the survey respondents from Study 1, the majority of whom trained at the Tavistock (58.6%), followed by the BPF (14%), as well as London being the most common location (43.7%), followed by Southern England (23.7%). Table 11 shows a breakdown of the types of work participants were conducting with the professional network around children in local authority care (individual child therapy has not been included as this was not the focus of this study). In addition to these types of work, participants commonly undertook assessments of children and families, as well as advising and making recommendations to local authorities and the courts regarding care planning.

Table 11

Types of work conducted by participants with the professional network around children in local authority care

Participant	Type of service	Types of work conducted with the professional network around children in local authority care
P1	Private practice	<ul style="list-style-type: none"> • Consultations with professionals. • Regular group with social workers from a fostering agency. • Foster carers groups. • Individual work with foster carers.
P2	LAC CAMHS	<ul style="list-style-type: none"> • Children's homes reflective groups. • Groups with various professionals from fostering agencies. • Individual work with foster carers.
P3	Specialist CAMHS for fostering, adoption and kinship care	<ul style="list-style-type: none"> • Consultation meeting with the network at the initial point of referral to the service, then ongoing network meetings as necessary. • Regular reflective group with social workers. • Individual work with foster carers.
P4	Generic CAMHS	<ul style="list-style-type: none"> • Network meetings at initial point of referral, prior to offering therapy. • Individual work with foster carers.
P5	LAC CAMHS	<ul style="list-style-type: none"> • Consultations to professionals. • Individual work with foster carers.
P6	Private practice	<ul style="list-style-type: none"> • Children's home reflective group. • Individual work with foster carers. • Training programmes for foster carers and schools.
P7	LAC CAMHS	<ul style="list-style-type: none"> • Consultations to professionals.

- Individual work with foster carers.
 - Planned manualised training programme for foster carers (in future).
 - Planned setting up of a support work discussion group to foster carers who mentor other foster carers (in future).
- P8 Private practice (retired from generic CAMHS)
- Previously ran a consultation service in CAMHS for children in local authority care.
 - Previously ran reflective groups with residential homes.
 - Currently runs a foster carer group in private practice.
- P9 LAC CAMHS
- Informal consultations with social workers i.e. without a referral being made to the service, as well as formal consultations to social workers and other professionals.
 - Termly reflective group for Independent Reviewing Officers.
 - Group sessions with fostering and adoption team social workers.
 - Training with foster carers.
 - Individual work with foster carers.

4.3.4 Ethical considerations

Ethical approval to conduct the study was granted by the UCL Research Ethics Committee in August 2016 (Project ID: 8293/002, see Appendix 6). It was anticipated that participants may give examples of clinical material during the interview. However, they were not asked to provide any information that could identify specific professionals, foster carers, or children under their care, or contravene their professional confidentiality and data protection procedures. Participants read an information sheet and signed a consent form prior to commencing the interview,

which detailed confidentiality, anonymity, and data protection procedures, and right to withdrawal (see Appendices 7-8).

4.3.5 Procedure

The interviews were conducted between August and October 2016. Six were conducted on the telephone, two in person, and one via Skype. The interviews lasted between 54 and 73 minutes. Participants were asked about the main needs of the network that they could help with as a child psychotherapist, as well as a description of the work they undertook with these practitioners. Questions also asked about how they understood the ways in which this consultation work might benefit the network, and indirectly benefit the child. Furthermore, they were asked about how their approach was distinct from other disciplines working with the network around these children, and finally any challenges they had encountered in their consultation work. As the interviews were semi-structured, there was scope to explore topics that arose during the interview in greater depth. The interview schedule can be found in Appendix 9.

4.3.6 Data Analysis

The interviews were audio recorded, transcribed verbatim, and uploaded into Nvivo 11, a qualitative data analysis software package (QSR International, 2021). Thematic analysis was used to analyse them (Braun & Clarke, 2006). Thematic analysis was chosen because I wanted to look for patterns of meaning in the data, for which thematic analysis is well suited. I considered using Interpretative Phenomenological Analysis (Smith et al., 2009), however this approach typically takes an idiographic focus, trying to understand participants' individual experiences and how they make meaning from them. Instead, the aim of the analysis was to draw out themes from the data that reflected the phenomenon of interest, namely participants' work with the professional network around children in local authority care, therefore thematic analysis was more suitable.

Braun and Clarke's (2006) approach to thematic analysis was used. Thematic analysis is a flexible approach in that it is purely a data analysis method and is not tied to any pre-existing epistemological position (Braun & Clarke, 2006). Despite this flexibility, it is important to be transparent about the assumptions that underpin the analysis, including epistemology. Epistemology can be defined as the theory of knowledge, and researchers need to consider and outline their epistemological position; that is, their assumptions about the nature of knowledge. Researchers should ensure their epistemology aligns with their methodology and research methods (Cresswell, 2014).

Braun and Clarke (2006) state that analysis can be approached in different ways, namely: inductively (codes and themes are drawn out from the data); deductively (codes and themes are developed using existing concepts); semantically (themes are derived from the explicit meanings of the data); latently (themes consider the underlying assumptions and concepts that inform the semantic content of the data); and conducted using an essentialist / realist paradigm (assuming an objective reality that is reflected in the data), or a constructionist paradigm (in which knowledge and reality is socially constructed and created).

The analysis followed a primarily inductive approach, in which codes and themes were derived from, and 'grounded' in the data (Braun & Clarke, 2020). However, when analysing the transcripts, I was aware of the literature on the psychoanalysis of organisations described in section 4.1.1, having undertaken a review of this literature prior to commencing analysis. Whilst this literature was not used to create a coding framework, it informed my thinking during analysis. In producing themes, both explicit (semantic) content was considered, as well as more implicit (latent) content. For example, I considered the underlying assumptions and ideas of participants, to progress the analysis beyond the 'surface' of what was said (Braun & Clarke, 2006). This is demonstrated across the three themes identified in the analysis, which centre around the tensions participants experienced in their consulting role; this sense of tension was not spoken about explicitly by participants.

In terms of epistemology, the analysis was approached from a social constructionist perspective. From this position, knowledge, experience and reality are viewed as socially constructed, rather than being inherent within individuals (Burr, 2015). This position argues that instead of a single, objective reality, which is there to be 'discovered', there exist multiple truths and perspectives; knowledge is

ultimately viewed as subjective and seen as arising from social interactions between people (Burr, 2015). Society, and the communities within it, bring knowledge into existence, through patterns of behaviour that develop over time within social settings (Slater, 2017). Emphasis is therefore placed on language, as a key component of human social interactions. Language allows people a means of understanding the world, and is viewed as shaping, and constituting, reality (Slater, 2017). From this it follows that knowledge is a dynamic and evolving process, constructed from shared experiences within communities (Slater, 2017). Further elaborations of this position can be found in Chapter 5, as study 3 was underpinned by a social constructionist perspective rooted in symbolic interactionism.

This position was adopted because as a researcher, I identify with the assumptions of social constructionism. In the context of this study, I consider that participants' realities were inextricably linked to their subjective experiences, accepting that multiple constructions of meaning are possible. While participants may assimilate their experiences at an individual level, I perceived that their narratives were shaped by various factors, including broader social and structural or organisational factors (Slater, 2017). The concept of relational selves is pertinent (Gergen, 1999), which is the self formed within relationships, and can change depending on the social structures or group affiliations that individuals ascribe to (Koro-Ljungberg, 2007). During analysis, I therefore thought about how participants' affiliations, and the historical and cultural contexts associated with them, provide a lens through which they view relationships, and how this may shape their narratives. For example, I assumed that their identity as a psychoanalytic child psychotherapist, and the shared meanings they have formed as a result of this affiliation, framed their thinking and action. The analysis focused on how participants perceived themselves in relation to others; within the context of this study, participants often compared their experiences as a psychoanalytic therapist with those of social workers and other professionals in the child's network. Participants' narratives were perceived to be a construction of self, formed from their relationships with others (Koro-Ljungberg, 2007). During analysis, I was also keen to explore how participants' thinking and interpretations of their role as consultant to the professional network influenced their actions.

A social constructionist perspective also holds the position that, during research interviews and analysis, the researcher is not a passive listener, but is

actively involved in the construction of knowledge and meaning (Koro-Ljungberg, 2007). As Koro-Ljungberg (2007, p. 431) states, the focus of collecting interview data from a social constructionist perspective shifts from 'mining individual minds' and instead to the 'coconstruction of (temporarily) shared discourses'. I therefore considered that the research interviews themselves were a negotiated process, in which my interactions with participants shaped the progress of the interview and the knowledge constructed (Koro-Ljungberg, 2007). This includes how I negotiated the 'rules' of the interviews, established rapport with participants, constructed my position as a researcher, and responded to participants' narratives. For example, occasions in which I shared laughter with participants, or I attempted to summarise something based on my own understanding of their narrative, will have impacted on the progress and development of the interview. In this way, dialogue has a transformative aspect (Koro-Ljungberg, 2007). The study's findings are not presented as an objective statement as to how participants experienced their role as consultant to the professional network, but instead include my subjective construction of participants' realities. I also acknowledge that the analysis was influenced by my own background, interests, and knowledge. This is explored further in Chapter 5 (section 5.3.6.5) in which aspects of my reflexivity are discussed, i.e. a critical analysis of my position during the research process and its contribution to the production of knowledge (Vindrola-Padros & Vindrola-Padros, 2018).

According to Braun and Clarke's (2006) approach, there are six stages to conducting a thematic analysis, namely: familiarising yourself with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report. However, Braun and Clarke (2006) acknowledge that during this process, the researcher is often going back and forth between the different stages during the analytic process. I started the analysis by repeatedly reading the data in an active way, noting down what I thought was going on in the data. I then organised the data into codes, which are at a more basic level than themes – which are much broader and involve a level of interpretation. Following this, I analysed the codes and drew out themes from them, then reviewed them to see whether they were working, by using thematic maps. At this stage I discussed my initial themes with my supervisors, who suggested some refinements to them, feeling that they were too descriptive at this stage and needed to be more interpretive. I therefore re-visited my analysis and refined my themes, again

discussing these with my supervisors until mutual agreement was reached. A more detailed example of how thematic analysis was used in this study can be found in Appendix 10.

In terms of the credibility of the analysis, an external researcher, who had knowledge of psychoanalytic theories but not specifically of child psychotherapy and children in local authority care, independently read and coded one of the interview transcripts. The purpose of this was to gain another perspective on the codes, compare it to my coding, and refine the coding system. Furthermore, as stated, I presented my initial analysis to my supervisors along with two interview transcripts, to enable them to review the development of themes and ensure that they were appropriately grounded in the data. Again, following discussion, further refinements were made to the themes and sub-themes. The study participants were asked to give feedback on the analysis, to ascertain whether they thought the themes represented their views on their work. Participants were emailed an anonymised version of the analysis, including quotations to be included. Four participants responded, all reporting that they thought the analysis resonated with their experiences of working with the network.

4.4 Results

The analysis identified that participants discussed various tensions in their experiences of consulting to the professional network around children in local authority care. The three themes set out each of these tensions, supported by data extracts from the interviews. Although not every participant spoke about each of the themes presented, they represent the overall story that participants were telling. Where suitable, the commonness of a theme is indicated, as well as differences of opinion.

4.4.1 Theme 1: The tension between the networks' wishes and what child psychotherapists feel they can offer

This theme encapsulated child psychotherapists' sense of a dilemma between what they felt is demanded of them by the network versus what they felt they can offer. All

participants perceived there to be great levels of unconscious anxiety within professional networks around children in local authority care, that manifested itself in various ways, including demands put on them as child psychotherapists. Nearly all participants described how common it was for professionals – those external to mental health services – to think that getting a troubled child into psychotherapy will ‘fix things’. Often these requests were for therapy to happen quickly; one participant described it as, ‘come on get them into therapy *now*’ (P4), while another said,

You’ve got a social worker and a foster carer and a teacher and maybe a parent as well and they’re all pulling their hair out because none of them really feel like they’re able to understand this child, and what they think needs to happen is the child needs to go into therapy. And once the child’s in therapy the *therapist* will understand the child. (P3)

Several participants, in reflecting on why professionals might be trying to get a child into therapy, thought that child psychotherapists were often seen as the most appropriate clinicians to engage these children. One participant said they were sometimes seen as ‘knight(s) in shining armour’ (P1), another that they were perceived as being able to wave a ‘magical wand’ (P6), and another that professionals can have ‘fantasies’ (P4) about what individual child therapy can achieve. Participants discussed feelings of disappointment from professionals external to mental health services when therapy was not offered immediately. They thought it was common for splits and a blaming culture to arise in these networks, including blame towards the child psychotherapist for perceived withholding of therapy, or of therapy not making the child better,

I think there’s something about that which gets into networks very strongly. That when something’s not working, or not going to plan, or there’s a deterioration, I think the reaction is – I’m talking very simply really, it’s a long winded way – blame has to be proportioned in a fractured network. (P6)

In trying to make sense of this, participants spoke of how these professionals were commonly subjected to extremely distressing and emotive situations, with children who projected their feelings of hopelessness into the whole network. One participant said that networks are often experiencing ‘secondary trauma’ (P4), ‘you know you get very bruised and battered, emotionally battered social workers and likewise with

the foster carers.’ (P4). Wanting to get the child into therapy, or blaming other services, was viewed as a way of alleviating professionals’ own anxieties about the child, or of transferring responsibility to another professional. Participants related the high levels of network anxiety, and the perceived resulting defences used, to the effects on professionals’ capacity to think about the child’s needs and perspective. This was not intended as a criticism, but as a response to the extremely emotive environments these professionals were working in. One participant said that it ‘paralyses thinking.’ (P9). Another participant said, ‘it all becomes about the adults views or the adults talking...and you’re thinking who’s bloody speaking up for the child here?’ (P6). This quote demonstrates the perception that it was their role as the child psychotherapists to ‘speak up’ for the child, and amongst respondents, the child’s view was sometimes described as becoming lost amongst network thinking.

Participants’ construction of their role as consultant to the professional network was often built around wanting to offer a different approach to that so often demanded of them. This was based around reformulating people’s thinking about the child’s problems; for professionals to understand that the solution isn’t always to get the child into therapy. They discussed how what was often needed in these cases was a thinking space *around* the child, before (or instead of) working directly with the child. They felt that primarily their focus was about offering a thoughtful, consultative capacity to the professionals who hold responsibility for the child, rather than leaping into individual therapy that was so often requested. There was a sense of needing to change perceptions of mental health professionals more widely; one participant said, ‘I think CAMHS tends to be seen as you know very much in the clinic’ (P4), thus indicating that CAMHS professionals were perceived as being suited to the more therapeutic aspects of practice with the child.

Several participants stressed that psychotherapy ‘only works under certain conditions’ (P8), emphasising that for the child, the first priority is usually to feel settled, and therefore providing support to the network – such as social care, education, and foster carers – may be more pertinent. Added to this was a feeling that it can be extremely difficult to engage some of these children in therapy. One participant said it was unfair to ask very unsettled children to ‘unpack all their defences and become very vulnerable when they don’t really know where they are going to be in their mind from week to week’ (P4), therefore suggesting that for these

children, they *need* to hold onto their defences during uncertain periods, and therefore therapy may not be appropriate.

Some participants thought their role entailed empowering the network to see the value in what they were already doing,

What they need...is for everybody else to know that they already have a mentor at school who they trust and who they are telling stuff to, or they talk to their foster carer in the evenings...and so that's already there, so you don't need to replicate that with a therapist...what you need to do is share that information with the other people, and use it to develop everybody's understanding. (P3)

Here the participant suggests that, by using initial consultations to gather information about the child's relationships with others in their network, they could help identify the provision of existing support, meaning that therapy was not always necessary.

4.4.2 Theme 2: *The tension between the way the system is organised and what is in the child (and networks') best interests*

This theme encapsulated child psychotherapists' sense of a tension between how the system is organised, and their role which may be to sometimes question whether this organisation is in the best interests of both the child, and the professionals working with them. Many participants spoke about the large, unwieldy networks often surrounding a child living in foster care, leading to situations in which they perceived that children's needs are overlooked, 'it's everybody's problem and nobody's problem' (P5). Several participants thought that whole networks sometimes tended to work reactively with these children – at times of crisis – rather than being able to think more preventatively. Four participants discussed their experiences of children being overlooked because they were not at crisis point, or displaying acting out behaviour,

If you've got a child who's more quiet and withdrawn...the notion can be in the system well they're fine because there's an absence of a difficulty...they're very resilient, that's what you'll hear...and so then having to then go back and

think about why you know the child may not feel able to reach out and ask somebody is really important. (P5)

Here the participant constructs themselves as a professional who takes a different stance to others in the network, in which their role is to consider aspects of so-called 'resilience', including unearthing emotions that may underlie the behaviour. This is contrasted to the understandings of other professionals in the network, therefore differentiating their unique understanding as a psychoanalytic child psychotherapist.

Participants perceived this organisational set up to impact on professionals as well. Although they discussed organisations who very much encouraged the provision of a protected space to think through cases and practice elements, it appeared in some instances that organisational pressures made it difficult for staff to coordinate attending and prioritising such meetings. One participant commented that the network is primarily led by statutory meetings, which have a very set agenda, and often do not allow those present to think about the child from different perspectives. Another participant commented that although professionals have supervision as an opportunity to discuss their cases, again this may be a different type of thinking space, with a focus often quite narrowly on issues of safeguarding,

I think in supervision people are pretty much just going through their caseload, thinking about risk...and there's not very much time for a more in-depth sort of thinking or analysis about what really might be going on for a child or for the network or for the...lead professional involved. And that may be leading to something getting very sort of blocked or blindspots...things that people just feel it's just unbearable to think about. (P9)

In this way it appeared that participants drew on a psychoanalytic framework of thinking about organisations as blocking staff from being in touch with their anxieties at a systemic level.

Some participants also discussed their own mental health services being under pressure. There was a clear tension between wanting to offer a particular approach, that participants felt could be beneficial for both the child and the network professionals, and being conscious of organisational targets. One participant said that CAMH services are often 'under a lot of pressure to close things' (P9) and that their preferred approach of leaving cases open, to enable the family and

professionals to continue accessing their support, 'can be a problem for us when we're having to gather data' (P9). Other participants in the private sector discussed concerns that services such as foster carer groups could be cut if attendance was poor, given the emphasis on saving money.

Another aspect of this theme was child psychotherapists' perception of having to resist organisational pressures when working with networks. Several participants had experienced having to escalate cases through social care management to get their views heard. Some participants commented that the network is organised around targets, whereas sometimes they felt it was their role to question whether those targets were in the child's best interests. This was particularly discussed in relation to the desire for children in local authority care to achieve placement stability and eventually permanence; viewed as the 'holy grail' by services and commissioners. One participant commented that their specialist LAC service had been set up to achieve higher rates of placement stability in their locality. However, there was a clear tension between maintaining stable placements and instances in which participants felt it was detrimental for the child to remain with a particular carer. As part of their consultant role extended to 'therapeutic management' (P1) support to foster carers, participants discussed instances in which they had worked with carers who were 'frightened by thinking' (P6) or for other reasons a placement was on the verge of breaking down,

If you can't kind of work with the foster carer then we would...have raised concerns about whether this is the right placement and suggested that this may put the child's stability at risk. And even though that sounds contradictory, think it is better to have a planned move than a breakdown. So we'd work very hard to try and see if the placement was viable cos another move is going to be very difficult and we'd try to put in as much thought as possible, but what we wouldn't do is paper over cracks that can't be fixed.
(P7)

There was a sense of dilemma in recommending a placement be terminated, viewed as potentially contentious with social care services keen to promote placement stability. However, participants maintained that an important aspect of their

consultant role was to recognise when a placement was not suitable, and to help manage that in a planned way.

4.4.3 Theme 3: The tension between a generic model of reflective practice and a psychoanalytic model of reflective practice

This theme encapsulated child psychotherapists' views about whether their approach to offering consultations is similar to models of 'reflective practice' offered by professionals from other backgrounds, or whether the psychoanalytic approach brought something unique to reflective practice. A couple of participants commented that any 'competent clinician' (P1) should be able to take on their role of network consultant, and many participants were working in multi-disciplinary teams sharing consultancy work amongst different mental health professionals. Several participants commented that consultation work within a multi-disciplinary team might often just be designated based on team members' availability.

Despite these perceptions and, in practice, cross-over in consultation work with other disciplines, most participants thought that psychoanalytically trained child psychotherapists brought something unique to reflective practice with professionals and foster carers around children in local authority care. For these participants, their perceptions of their consultant role therefore appeared to be closely underpinned by their affiliation as a psychoanalytic therapist. In terms of the content of sessions, several participants discussed experiences of professionals (external to mental health services) and foster carers requesting quite structured consultations and advice on behavioural strategies to help manage the child's behaviour; these requests were viewed as, in a sense, them wanting solutions from the child psychotherapist,

I feel it's often about some wish that there would be just an easy answer or a solution, some you know sort of, well as I say strategy that's going to resolve this or sort it out or stop this child doing this or make life easier, rather than thinking about you know the child may be responding to something or communicating...that things feel completely chaotic or they feel very

frightening or you know that they want to make you feel very intimidated because you know they feel so helpless. (P9)

As the above quote demonstrate, participants spoke about wanting to offer a different approach; less structured and focused on behaviour management, and instead on being curious about the child's mind and what they may be communicating. Thus, they aimed to encourage professionals and foster carers to think from the child's perspective, in order to understand unconscious patterns of behaviour and relating: 'a lot of the children who are aggressive or their problems are what people refer to as behavioural...we will try and help them reframe that as anxiety or distress.' (P7). Several participants discussed trying to 'slow things down' during consultations, in working environments where speed and efficiency are often prioritised. This included examining and unpicking individual incidents with a child or family in detail. Participants talked about wanting to impart to the network the observational skills they learnt during their training, encouraging professionals to make sensitive observations of the child, rather than always needing to have a clear formulation of the child's problems and strategies for responding.

Participants also discussed their focus on creating an unstructured space that was not action-oriented, but instead conducive to encouraging thinking and allowing thoughts to emerge. The aim appeared to be to create a containing space - drawing on Bion's (1962) concept of container-contained - in which anxieties could be received, thought about, and returned to them in a more tolerable form,

I think even just the process of thinking and being able to touch upon these maybe unspeakable things, I think begins to help, I think it contains by saying look it's not frightening, you don't have to be ashamed of these things. They're not untouchable, they can be managed. And that's containment. (P6)

Participants hoped that the provision of this unstructured, non-directive space could enable professionals and foster carers to stay with the uncertainty in these incredibly emotive situations, and for it to become less frightening and more manageable. Several participants mentioned that they sometimes took more of a 'backseat' (P3) role in large network meetings, particularly when splits or a blaming culture were occurring between services. These participants talked about using their observational skills to interpret the dynamics that were at play, and subsequently

their role in putting into words the anxiety and tensions underlying practitioners' defensive responses. Verbalising anxieties was used as a means of enabling thinking to become 'unstuck', encouraging workers to be more in touch with their own feelings, acknowledging the impact of the work on them, and considering the perspective of other professionals: 'we could think about that in a way that wasn't just about "you two don't like each other" but somehow it would often arise out of different ideas they had about what a particular young person needed' (P2). In this way, decisions could be made collaboratively with professionals who were thinking again, rather than on a defensive need to prematurely try to solve extremely difficult situations. Thus, the action in the child psychotherapists' approach was the provision of containment, so that unconscious anxieties could be made conscious and reflected upon in a non-critical, safe environment. However, there was some discussion about the fine line between breaking down professionals' defences, and acknowledging instances in which, in order to keep practising, they may need to hold on to them,

So it's to put words around emotions as much as possible or as much as somebody can manage, because sometimes you pick up that people can't, that somebody just can't manage this so that informs the level at which you work with them. (P4)

A related aspect fundamental to the child psychotherapists' construction of their role was for them to not always take an 'expert' position during consultation. There was a clear tension between child psychotherapists' perception that they were viewed as experts by other social care professionals, but not always wanting to take up such an 'expert' position in consultations, as this could just leave those seeking help feeling even more unskilled. Whilst participants discussed occasions in which they did give advice and were involved in decision making, more often their approach was to be curious and ask questions of professionals. In turn they hoped this would encourage professionals to be more curious themselves, rather than the child psychotherapist coming across as 'omnipotent' (P7). One participant emphasised that it was important for professionals and foster carers to recognise that they did not always need to know the answer to difficult situations. Again, they hoped this would allow

them to better tolerate the anxieties and uncertainty inherent in this work and continue to stay with that uncertainty.

4.5 Discussion

The aims of this study were to gain an in-depth understanding of child psychotherapists' work with the professional network around children in local authority care; in particular, to explore child psychotherapists' perceptions of their role with the network, and what they see as specific to the psychoanalytic approach. Participants in this study were working with various agencies around these children, and their work entailed different functions, namely: contributing to network meetings or individual consultations with professionals; ongoing, regular groups to provide a space for reflective practice amongst the network; groups addressing aspects of network anxiety and dynamics; and direct work with foster carers, either in an individual or group setting. Other aspects of participants' work included training with foster carers and other professionals, assessment work, and advice to local authorities and the courts regarding care planning.

This is the first research study to explore this area of a child psychotherapists' work and highlights the range of work conducted in routine clinical practice across different settings – both in generic CAMHS teams and targeted LAC CAMH services, as well as private practice. Although participants were working in different ways, they all had more than one element to this aspect of their work and there were some commonalities to the functions of their roles. This study has built on previous research (Robinson et al., 2017; Sherwin-White et al., 2003) demonstrating that child psychotherapists' work extends beyond the 'traditional' role of individual child therapy.

The thematic analysis identified three themes around child psychotherapists' sense of tensions and dilemmas in their experiences of consulting to the professional network around children in local authority care. The first theme *'the tension between the networks' wishes and what child psychotherapists feel they can offer'* encapsulates participants' sense of a dilemma between what is demanded of them by the network – often for the child to receive individual therapy – versus wanting to offer an alternative, more network led approach when they thought the conditions

were not right for therapy. Participants perceived there to be high levels of conscious and unconscious anxiety amongst network professionals, leading to reduced thinking capacities regarding the child's needs. Participants described a framework for understanding how these networks managed their anxiety as defensive strategies, including a blame culture and splitting across services and within teams and a common desire to get the child into therapy quickly so that the therapist will 'fix' them. Participants' felt that the effects of this anxiety hindered professionals and foster carers' abilities to think about the child's needs and perspective, with the child often being described as 'lost' amongst this chaotic network thinking. The detrimental impact of these defences on professionals' capacity for thinking has been previously noted within the child psychotherapy literature (Briggs, 2004; Emanuel, 2002; Hoxter, 1983; Hunter, 2001; Rocco-Briggs, 2008; Sprince, 2000). This study's findings add to the literature by providing an understanding of child psychotherapists' experiences of their role as consultant to the professional network, particularly the tensions they experience within their role.

Bion's writings about the impact of trauma can be used as a framework for understanding this reduced thinking capacity, conceiving of the professional network as making attacks on linking, namely attacking associations between thoughts and therefore hindering their ability to know (Bion, 1959). This also links to Bateman and Fonagy's (2006) theory of mentalizing, in which failures in the development of the capacity to mentalize i.e. to have mental representations about the mental states of self and others, are reflected in high levels of splitting mechanisms among patients with borderline personality disorder. Although participants in this study did not offer this perspective themselves, it could be conceived that this common splitting amongst professionals in networks around these children represents a temporary loss of the mentalization capacity, as a result of the secondary trauma and high levels of anxiety experienced. Furthermore, the defence mechanisms described by participants could also be viewed as a predominance on pre-mentalizing states, for example professionals' desire to get the child into therapy quickly so that the therapist can 'fix' them, can be viewed as teleological mode (Fonagy & Target, 1997), in which there is a focus on physical action and solutions. Similarly, the perceived blame culture and conflicts often arising in networks around these cases could be viewed as the pre-mentalizing state of psychic equivalence (Fonagy & Target, 1996),

in which the chaotic thinking is not recognised as such but instead viewed as absolute reality.

These findings have some commonalities with the existing literature on the psychoanalysis of organisations (Britton, 1983; Hinshelwood & Skogstad, 2000; Jaques, 1955; Menzies-Lyth, 1960). There are clear parallels between the defensive techniques listed by Menzies-Lyth (1960) and those that participants in this study perceived to be shown by professionals and foster carers. This study has added to the literature on the psychoanalysis of organisations by showing that these defensive strategies may also be employed outside healthcare settings, in corresponding environments such as social care, whereby professionals are working closely with children with traumatic histories. Within the social care literature, Ferguson (2018) has argued that reflective practice theory needs to be underpinned by the concept of the defended practitioner. Although some critical analysis papers have applied these concepts to social care as organisation (e.g. Cooper, 2010; Lees et al., 2013), this has mainly been within the field of child protection, and little has been written pertaining this perspective specifically to children in local authority care. This study suggests that this perspective is shared more widely by psychoanalytically-trained child psychotherapists working with the networks around children in local authority care. Furthermore, this study also shares some commonalities with the child psychotherapy literature, which has similarly described divergences in networks around these children, particularly supporting Emanuel's (2002) assertion of the 'triple deprivation' this places on children.

Participants described wanting to offer an approach in which a thinking space was created *around* the child, for example encouraging network professionals to see the value in what they already do, rather than adding another professional to the child's network by always offering psychotherapy. It was abundantly clear that increasing the thinking capacity of the system was viewed as an agent of change in making the network think about the child's needs again, and in unifying fractured networks into a cohesive thinking system. Although participants did not frame it using this model, this shares commonalities with recent mentalization-based approaches for hard-to-reach youth. The AMBIT model (Bevington et al., 2013) aims to enhance team and network functioning by encouraging workers to support each other's mentalizing, acknowledging that it is common for professionals working with such youth to lose their mentalizing ability, and for networks to disintegrate. AMBIT

assumes that disintegration within networks around these young people is therefore expected, inevitable, and understandable; aiming to reframe practitioners' thinking that disintegration indicates the network has 'got it wrong'. Practical tools are provided to address disintegration, by thinking about which parts of the system may be supporting or impeding integration. The model also aims to scaffold existing relationships within networks, by encouraging network members to support a key professionals' mentalizing. This shares some commonalities with the approach outlined by participants in this study of wanting to identify existing support within the network rather than always undertaking psychotherapy. Also, from a mentalizing perspective, participants' role in helping professionals to see that direct work with the child might not always be the answer, can be viewed as countering the teleological mode thinking discussed previously.

The second theme, *'the tension between the way the system is organised and what is in the child (and networks') best interests'*, captures participants' sense of a tension between the way the system is organised, primarily around targets, and their role which may be to question whether this organisation is in the best interests of those in the network. Several participants spoke about children being overlooked by the system because they were viewed as 'resilient'; this resonates with Boswell and Cudmore's (2017) qualitative research study around children transitioning from fostering to adoption, finding that the adults often viewed children seemingly unaffected by major losses as 'fine' because they did not overtly display their distress. Participants discussed experiences of having to 'push back' against organisational pressures, and instances in which the provision of a protected, reflective space was not prioritised. Again, these perceptions can be made sense of in terms of the anxiety-defence model of organisations; defences at an individual level are perceived to become part of the organisational culture, and are subsequently upheld at the systemic level (Jaques, 1955; Menzies-Lyth, 1960). These findings are also congruent with literature around the current socio-political climate of social care, with the impact of austerity on Children's Service leading to increased target and audit cultures and a preoccupation with risk (e.g. Broadhurst et al., 2010; Hingley-Jones & Ruch, 2016). Hingley-Jones and Ruch (2016, p. 237) note that in this climate, practice can become 'combative' rather than 'compassionate.' Finally, as part of this theme, some participants discussed the tension within themselves between maintaining stable placements, and instances in which they felt

it was detrimental for a child to remain with a foster carer. This suggests that, while achieving permanence may be viewed as the 'holy grail' by services and commissioners, one aspect of the child psychotherapists' consultant role was to consider when a placement should be terminated, and how to manage this in a planned way.

The third theme, *'the tension between a generic model of reflective practice and a psychoanalytic model of reflective practice'*, captured participants' discussion about whether their role as network consultant is distinct from professionals from other disciplines, who may not use a psychoanalytic framework. Most participants thought that the psychoanalytic approach had something unique to offer to consultancy in terms of providing an unstructured, non-directive, containing space, allowing thoughts to emerge, and for anxieties to be made conscious and reflected upon. For these participants, their perceptions of their consultant role therefore appeared to be closely linked to their identity as a psychoanalytic child psychotherapist. They hoped the provision of this space also allowed professionals to tolerate the uncertainty inherent in these highly emotive working environments, and for decisions to be made collaboratively rather than on a defensive need to solve unbearable situations. Several participants explicitly related this to Bion's (1962) theory of thinking, in which the child psychotherapist acts as the thinking apparatus (the container) needed for the production of thoughts (the contained). Based on Bion's theory, the child psychotherapist can be conceived as performing alpha function for other professionals and foster carers, by creating a receptive environment in which their anxieties can be received, thought about, and returned to them in a more manageable way.

Although there are some similarities between Bion's theory and the mentalizing approach discussed above, there are also some differences; for example Vermote et al. (2012) note that mentalization-based treatment involves the therapist taking a much more 'active' stance in encouraging patients to mentalize about minds, whereas working under Bion's model, therapists would instead focus on creating a receptive and open environment conducive to the patient exploring their feelings. This parallels the findings of this study, in which child psychotherapists were taking both an active approach in helping professionals and foster carers think about the child's mind and the minds of their colleagues, and also aiming to create a space in which professionals' anxieties could be contained. This perhaps lends

support to recent research suggesting that, despite their differences, Bion's theory of thinking and Bateman and Fonagy's theory of mentalizing can be integrated in treatment (Mantilla Lagos, 2007; Vermote et al., 2012). Several participants in this study, either explicitly or implicitly, appeared to be integrating both theories in their practice and technique when working with professionals around these children.

Some participants acknowledged that they had to judge whether professionals were able to manage this work, and that there may be instances in which they need to hold on to their defences to keep practising. This is in line with Ferguson's (2018) ethnographic study of child protection teams, finding that there are times in which, to enable self-preservation in an emotionally demanding role, practitioners choose *not* to reflect.

Comparing these findings to other models of reflective practice, particularly in the social work literature, suggests that psychoanalytic child psychotherapy can bring some unique elements to consultancy work with the professional network, which has not been discussed by previous literature. Whereas other models, such as action learning (see Abbott & Taylor, 2013), prioritise reflection as a process to producing subsequent action, this psychoanalytic consultation focuses on a different type of action – the 'action' is the containment of conscious and unconscious anxieties. Participants clearly emphasised their stance of not providing behavioural strategies to manage the child's behaviour, viewed as a wish to 'solve' intolerable situations. This is in contrast perhaps to other models of consultation, for example those informed by social learning principles, which may advocate the use of behavioural techniques. Nor did they intend to act as 'experts' who provided explanations of behaviour to professionals. In terms of the format of sessions, the relatively unstructured, non-agenda led, format is also distinct from other models, even those that are psychoanalytically informed. For example, work discussion groups (Rustin & Bradley, 2008), although psychoanalytically based, follow a specific structure that is not present in this form of consultation. Again, the aim of this format appears to be the provision of a containing space in which professionals can begin to tolerate and manage uncertainty. Cregeen (2008) has linked this form of consultation to the process consultancy described by Obholzer and Roberts (1994), in which the work is very much 'emotionally alive' (p. 174), with attention paid to relational processes occurring in the room; in contrast to models based on case discussion 'where the disturbance is discussed at one remove' (p. 174). The form of

consultancy described by child psychotherapists in this study is therefore an active process in which the child psychotherapist responds to professionals' communications dynamically in the here-and-now. The proposed mechanism of change is that professionals develop an understanding of how they may protect themselves from the feelings generated by the nature of the work (defences), and how these can create risks to both the individual and the task of the organisation. Having this awareness, and learning to tolerate some of the painful emotions which the work generates in them, may allow them to connect with their own feelings; in turn helping them to think more fully about the child's needs.

4.5.1 Strengths and Limitations

This study used qualitative methods to gain an in-depth understanding of child psychotherapists' work with the professional network around children in local authority care. This was particularly useful in building on the findings of study 1, which identified that survey respondents conceived this area of their practice as an important area of development for services. Due to the nature of the survey methodology, this was not able to be elaborated on in further detail.

The study participants were nine child psychotherapists working in three settings (generic CAMHS, specialist LAC CAMHS, and private practice). These settings were chosen purposely because of their prevalence in study 1, which identified them as the most common workplace settings amongst survey respondents working with children in local authority care. This study provides evidence of child psychotherapists' work within three 'real-life' settings, which shows the transferability of the findings across different settings. Moreover, psychoanalytic child psychotherapists in the UK have fairly homogeneous training, and participants in this study used a consistent range of theoretical views to frame their discussion. However, while these views may represent UK psychoanalytic child psychotherapists, it cannot be said that they transfer to other types of child psychotherapists.

Furthermore, the sample was limited in the respect that it was reliant on child psychotherapists who provided their contact details on completion of study 1 and subsequently responded to an email asking for participation in study 2. This resulted in a sample of nine participants. However, by the end of the interviews, I felt that I

was not obtaining new information, therefore it is likely that saturation had been reached. The majority of interviews were conducted over the telephone, which may have affected rapport and opportunities to pick up on visual cues, although some research has argued that telephone interviews can be advantageous in allowing participants to feel more relaxed and willing to discuss sensitive topics (Novick, 2008).

In terms of the limitations of using thematic analysis, I was primarily looking for patterns of meaning across the data, which could coalesce into themes and sub-themes. Although divergencies in participants' opinion were noted, it is conceivable that using this approach meant that participants' individual experiences and views were not represented fully. Despite this, thematic analysis was the most suitable form of analysis for this study given the research questions and aims.

4.5.2 Conclusion and implications for study 3

This study explored the child psychotherapists' role as consultant to professional networks around children in local authority care. The main finding was that participants experience various tensions in their consulting role. In certain key ways, their approach to consultation appears to differ to other models of reflective practice used in social work. Many participants were using a model of working with foster carers and other professionals that, whether explicitly or implicitly, used ideas from Bion's theory of thinking in addition to having some similarities to a mentalization-based approach. However, this study could not identify how such an approach functions in the context of a multi-disciplinary social work setting. Study 3 aims to build on the previous studies by exploring in-depth how psychoanalytic child psychotherapists function within a specialist children's social care setting, particularly considering how they position themselves in a multi-disciplinary team and multi-agency setting, and any tensions that arise from their role. Considering study 2's findings were based only on data from child psychotherapists themselves, study 3 will include the views of social workers and other professionals in the child's care network. This should lead to greater data triangulation and exploration of whether child psychotherapists' views are echoed amongst other professionals, including those who may have been recipients of consultations from child psychotherapists.

5 Study 3: Psychoanalytic child psychotherapy within a multi-disciplinary CAMHS team, in a children's social care setting: an ethnographic, grounded theory study

5.1 Introduction

One of the main findings from the previous chapter was that child psychotherapists experienced various tensions they held within themselves in their role as consultants to the professional network around children in local authority care. These tensions were particularly around wanting to offer a different, more network-led approach, even though other professionals were often asking for them to provide individual therapy. The study also explored how child psychotherapists perceive their contribution of providing reflective practice to the professional network. Most participants thought the psychoanalytic approach offered something unique in terms of providing a space for professionals to begin to tolerate uncertainty, for anxieties to be made conscious and reflected upon, and for the network to make decisions collaboratively, rather than being based on a defensive need to solve unbearable situations.

This chapter describes the third study of the PhD. This study aims to build on the findings of the previous studies by exploring in-depth the services provided by child psychotherapists, working in a specialist LAC CAMHS team, in a children's social care setting. The previous chapter has already reviewed some of the literature relevant to this study, namely child psychotherapists' role as consultant to the professional network around children in local authority care, and psychoanalytic perspectives of dynamics that can occur within networks. This chapter will therefore contextualise the study by reviewing the literature relevant to the setting within which the child psychotherapists, who participated in the study, operated. This includes literature and policies surrounding multi-disciplinary working in CAMHS teams, and literature regarding multi-agency collaboration within children's services.

5.1.1 Multi-disciplinary working in CAMHS

CAMHS are the NHS run services for children in the UK. The Health Advisory Service's *Together We Stand* document (HAS, 1995) introduced a four-tiered system for commissioning and organising CAMH services. This strategy aimed at improving mental health services for children and young people, with core principles including accessibility, comprehensiveness, integration of agencies, and multi-disciplinary teams. The stipulation of multi-disciplinary working ensured that children and young people could access the most appropriate service for their needs, as well as enabling a mix of theoretical frameworks, training, and knowledge amongst professionals within teams. CAMH services across England are organised locally and vary in size and remit, but typically include professionals from disciplines including psychiatry, psychology, social work, nursing, occupational therapy, family therapy, and child psychotherapy, among others. Although the HAS strategy documented the role of different professions within child mental health services, it also included a set of essential, generic competencies that each service should have (Baldwin, 2008).

Since then, several researchers have noted the increasing policy shift towards what has been termed 'creeping genericism' within mental health services, including CAMHS (Brown et al., 2000; Hill-Smith et al., 2012). The Audit Commission's *Children in Mind* report (Audit Commission, 1999) placed emphasis on core skills that CAMH services should have, advising that services should rationalise the skills mix within teams and defend the contribution that individual professions make (Baldwin, 2008). In 2004, the National Institute of Mental Health in England published its *Ten Essential Shared Capabilities* as a framework for the entire mental health workforce, which included best practice guidance on capabilities that all staff are expected to have (Department of Health, 2004c). Also, in 2004, *New Ways of Working for Psychiatrists* was introduced (Department of Health, 2004a); although this guidance was originally intended for psychiatrists, it recognised its impact on allied professions in mental health. Subsequently working groups were set up from several professions, culminating in the 2007 report *Mental Health: New Ways of Working for Everyone* (Department of Health, 2007). *New Ways of Working* brought

about a change in the guidance for mental health professionals, including emphasis on generic skills. The intention was to create more flexibility, so that different professionals could manage a variety of responsibilities (Hill-Smith et al., 2012). Also came the introduction of more generic, hybrid, mental health posts – such as mental health practitioners and primary mental health workers – who could come from different professional backgrounds. This role blurring has been viewed by several authors as a potential corrosion of professional identity (Frost et al., 2005; Robinson & Cottrell, 2005). Others have noted that, contrastingly, role blurring can result in individuals strengthening their own sense of professional identity, to avoid losing it (Hill-Smith et al., 2012; Lankshear, 2003). Hill-Smith et al. (2012) argue that professional identity within CAMHS needs to become more flexible to be in keeping with New Ways of Working, for example recommending that practitioners incorporate other theoretical frameworks into their own understandings. They term this, 'new ways of thinking'.

Strong relationships amongst multi-disciplinary team members are important for ensuring effective CAMH services (Hill-Smith et al., 2012). Within the literature, there is a body of evidence exploring experiences of multi-disciplinary working among adult mental health practitioners (Brown et al., 2000; Jones, 2006; Lankshear, 2003; Larkin & Callaghan, 2005; Workman & Pickard, 2008). However, studies examining multi-disciplinary relationships amongst child and adolescent mental health practitioners are more limited. Walker (2003) reports on the evaluation of a government funded pilot family support service, where professionals were employed by their own agencies but came together as a team. He found that team members largely relished the opportunity to work in a multi-disciplinary environment, where ideas and knowledge could be shared between different disciplines. Team members thought this way of working fostered flexibility, a willingness to listen to other professionals' perspectives, and space for reflection. However, they struggled to achieve full cohesion as a team, given they were funded by different agencies. In another study, Hill-Smith et al. (2012) explored the interactions between four disciplines within a CAMHS team. They argued that there are many possible interactions between these professions, some positive, and some negative; and these are changeable depending on the context and individuals. They propose that an understanding of possible interactional patterns among CAMHS professionals will enable better communication and effective working relationships.

Granville and Langton (2002) offer systemic and psychoanalytic perspectives on working across professional boundaries within multi-disciplinary teams. They describe the working practices of a specialist treatment service for young children and their families. A core issue for the team was negotiating relationships between different disciplines, particularly balancing discipline-specific skills and knowledge, versus adopting generic working practices, which on a practical level allowed them to operate in a more flexible way. The authors propose that psychoanalytic thinking is useful in enabling multi-disciplinary services to recognise dynamics and hierarchies occurring within teams. These include the potential replication of family dynamics within professional teams, such as nurture, control and dependence. Team members can also recognise their responses to each other and the work. This awareness of transference and counter-transference responses can help professionals to recognise splitting processes within the team. Furthermore, an understanding of defences against anxiety, such as denial, can enable professionals to become aware of how they may protect themselves against the emotive and painful nature of the work. Granville and Langton (2002) emphasise the importance of reflective, receptive spaces to vocalise and metabolise overwhelming feelings, drawing on Bion's (1962) concepts of containment and reverie. Dennison et al. (2006) offer a similar application of psychoanalytic principles to understanding the relational aspects of teamwork within children's services.

In another clinical paper, Youell (2002) reflects on the place of child psychotherapy in a multi-disciplinary team providing assessments regarding care proceedings, for families where there are child protection concerns. Youell (2010) describes her promotion of psychoanalytic observation amongst team members as a means of informing assessments, including encouraging them to recognise their counter-transference responses during observations. She provides case examples of using psychoanalytic infant observation to recognise that so-called 'resilience' in a child may instead reflect withdrawn or cut-off feelings, or an underlying psychopathology.

These papers demonstrate the potential value that a psychoanalytic framework can offer to multi-disciplinary working. However, no research studies have explored the unique contribution and perspective of psychoanalytic child psychotherapists in a multi-disciplinary CAMHS team. This is particularly relevant

given the context of 'creeping genericism' within CAMH services, and the need for disciplines to establish their distinct contribution to multi-disciplinary teams.

5.1.2 Multi-agency working in children's services

Multi-agency working within children's services has been a central feature of UK policy documents for several decades (Salmon, 2004). In 1998, the Quality Protects initiative (Department of Health, 1998) produced policy guidelines for improving children's social services, including a focus on multi-agency collaboration with agencies including CAMHS. The 2003 government Green Paper, *Every Child Matters* (Department for Education & Skills, 2003), recommended that children's services be joined together in Children's Trusts, recognising that no one agency can solely address a child or young person's needs, and that integrated working is an efficient way of delivering services (Salmon, 2004). Alongside this, the National Service Framework for Children, Young People and Maternity Services (NSF) (Department of Health, 2004b), aimed to provide national standards for all children and young people's services, viewing multi-agency collaboration as essential in developing effective services.

Mental health policy for children and young people has also placed an emphasis on multi-agency working. The Audit Commission Report (1999) argued that specialist CAMHS needed to give greater focus to collaboration with other agencies, concluding that only 2% of time was spent providing consultation to other services. In 2011, the Children and Young People's Improving Access to Psychological Therapies Programme was introduced in England, delivered as a partnership between CAMHS and other services including local authorities and the charity and voluntary sectors (Department of Health, 2011). More recently, the Department of Health and NHS England's Task Force on Children and Young People's Mental Health and Wellbeing's report *Future in Mind* recommended a 'whole system' approach around the child or young person to address their mental health needs (Department of Health & NHS England, 2015).

There are currently a variety of models of multi-agency working in practice. These are often described in terms of how multi-agency working is organised – ranging from collaboration at a strategic level; to centre-based service delivery,

where services are co-located in one place but function separately; to multi-agency teams, where professionals from different agencies work together in a team (Atkinson et al., 2002; Cameron et al., 2012; Sloper, 2004). Other approaches to classifying models include the extent of multi-agency working – ranging from information exchange at one end of the spectrum, to full partnership, with shared agenda and values, at the other (Atkinson et al., 2007).

Despite widespread recognition that multi-agency collaboration is essential for promoting effective services for children and young people, this can be difficult to practice on the ground (Bullock & Little, 1999; Salmon, 2004). Several studies and reviews have explored facilitators and barriers to achieving effective multi-agency working in children's services (Cameron et al., 2012; Robinson & Cottrell, 2005; Sloper, 2004; Wong & Sumsion, 2013), including collaboration specifically between CAMHS and other agencies (Salmon, 2004). Barriers to multi-agency working within children's services include communication breakdowns, differences of opinion surrounding interventions, lack of trust between agencies, resource issues, differences in prioritising cases, and conflicting service aims and policies (Anning et al., 2010; Easen et al., 2000; Salmon, 2004; Worrall-Davies & Cottrell, 2009). Tensions can also arise when agencies must negotiate authority and hierarchy (Granville & Langton, 2002). Miller and Ahmad (2000) identified additional barriers to effective joint working, specifically regarding CAMHS' collaboration with other agencies. These included dominance on the medical model within CAMHS, lack of understanding of other agencies' cultures, and lack of a 'common language' between agencies. Worrall-Davies and Cottrell (2009) concluded that perceptions of outcome research and evidence-based practice may be an additional barrier to effective collaboration between agencies; while health services prioritise evidence from controlled trials, other services may give more credence to evidence such as service users' experiences.

Conversely, other research has identified factors that facilitate multi-agency working in children's services (Atkinson et al., 2007; Cooper et al., 2016; Doyle, 2008; Harker et al., 2006). Atkinson et al.'s (2007) systematic review concluded the following four aspects as contributing to effective working: good working relationships, including mutual trust and respect, clear roles and responsibilities; multi-agency processes, including clear lines of communication between agencies; adequate resources and co-location of services where possible; and robust

management and governance. Adequate information sharing has also been identified as an important facilitator (Harker et al., 2004; Robinson & Cottrell, 2006). Cooper et al. (2016) conducted a systematic review of factors that enable and hinder multi-agency collaboration specifically within child mental health care, concluding that they fit well within Atkinson et al.'s (2007) taxonomy as described above, but that evidence is limited regarding the effect of multi-agency collaboration on clinical outcomes.

5.1.3 Multi-agency working for children in local authority care

The importance of multi-agency working between health, education and social services has been particularly recognised regarding vulnerable children and young people, including those in the care system (Biehal et al., 1995; Department of Health, 2009). Street and Davis (2002) outline several tensions that can occur when CAMHS and social services do not work collaboratively around children in local authority care. These include the perception from CAMHS that mental health support is best offered at times of stability, which may feel frustrating for social care. Furthermore, CAMHS professionals may feel that problems are being situated within the child themselves, when they perceive the problem to be in the wider system, among the network professionals. Street and Davies (2000) conclude that by working closely together, agencies can begin to understand each other's perspective, resulting in more appropriate planning and decision-making for the child.

Indeed, it has been argued that children in local authority care, given the complexity of their difficulties, have different treatment needs to those offered by generic mental health services (DeJong, 2010; Street & Davis, 2002). This is reflected in the development of specialist LAC CAMH services, and dedicated, integrated multi-agency services to address these children and young people's needs (Callaghan et al., 2004; Golding, 2010; McAuley & Young, 2006; Ward et al., 2002). Rao et al. (2010) examined the characteristics and referral patterns of looked after and adopted children attending a specialist CAMH service over a one-year period, finding that although the service applied the same general principles as generic CAMHS, there were some notable differences. These included more outreach work, more flexible therapies tailored to the child's individual experiences of

trauma, and difficulties with engaging children to attend services. The potential benefits of specialist, integrated services for children in local authority care include targeted interventions adapted to meet the individual needs of the child or young person, strengthened communication between agencies, a greater understanding of other agencies' priorities, and easier access and referrals to services (Golding, 2010). Several evaluations have been undertaken, for example Callaghan et al., (2004) found that children in local authority care referred to a designated service improved on a range of mental health outcomes.

The research outlined above highlights the potential benefits of specialist multi-agency services for children in local authority care, particularly concerning their mental health needs. There is a need for research to explore how psychoanalytic child psychotherapists position themselves in a multi-agency setting, and their unique role and voice in multi-agency collaboration around children in local authority care.

5.1.4 *The present study*

Given the previous literature concerning multi-disciplinary and multi-agency working in CAMH services, there is a need to establish the role and contribution of individual disciplines to collaborative working practices, especially for children with complex needs such as those in the care system. Despite most UK psychoanalytic child psychotherapists working in CAMH services (Rance, 2003), research establishing the contribution and perspective of child psychotherapists within multi-disciplinary CAMHS teams, as well as with other agencies, is lacking. The first study of this PhD research, a national survey of UK psychoanalytic child psychotherapists, identified that a proportion of child psychotherapists surveyed were working in specialist CAMH services for children in local authority care (17.2% of a sample of 215 respondents).

Given the literature reviewed here around the 'creeping genericism' of mental health services, there is a need to understand how child psychotherapists can integrate themselves into multi-disciplinary teams whilst also retaining their distinct professional identity. There is also a need to understand how child psychotherapists, operating within multi-disciplinary CAMHS teams, can work effectively with other

agencies to provide high quality services that support these children's mental health needs. This is particularly so for collaborations with social care, as the corporate parents and key decision-makers for children in local authority care.

This study explores this through an ethnographic case study of child psychotherapists working in a specialist multi-disciplinary LAC CAMH service, based in a social care setting. The two agencies (CAMHS and social care) are co-located but are funded and operate under two separate governing bodies (the NHS and local authority). Using Atkinson et al.'s (2002) taxonomy, they are therefore an example of centre-based working, rather than fully integrated services who operate as one team. This is useful for exploring how two co-located agencies collaborate, but also any tensions that get played out in the setting due to them functioning as separate services.

5.2 Study Aims

The overarching aim was to develop a theory of how psychoanalytic child psychotherapists function within a multi-disciplinary CAMHS team, in a children in local authority care social care setting. This study provides understanding of the role of child psychotherapy and psychoanalytic thinking in this setting, particularly considering the potentially differing views of professionals working with children in care. The findings of this study have implications for the future of the child psychotherapy profession, for example how the profession can meet the needs of social care, drawing on their core psychoanalytic training and providing a service that they feel best supports children in local authority care's emotional wellbeing. It also has implications for how services should be designed to best meet the particular needs of these children and young people.

The research question was: How do psychoanalytic child psychotherapists function within a multi-disciplinary CAMHS team, in a children's social care setting? This was particularly explored in relation to:

- The distinct role and contribution of psychoanalytic child psychotherapists in this setting;
- How the child psychotherapists position themselves in a multi-disciplinary CAMHS team;

- How the child psychotherapists position themselves in a multi-agency setting, working alongside social care;
- Any tensions that arise from their role in this setting.

5.3 Methodology

5.3.1 Research design

The research design is an ethnographic case study. Case study research has been used across several disciplines, with different models in existence, often stemming from the epistemological assumptions of the researcher (Merriam, 2009; Stake, 2006; Yin, 2009). Despite this, there are commonalities across approaches that define this type of research. Yin (2009) defines a 'case' as referring to either a single individual, or another entity such as an organization, a community, or a process; and there can be single or multiples cases. Case studies are primarily used for explorations of complex issues in a real-world setting, with the aim being to understand a phenomenon in-depth from the perspectives of participants. This design is particularly suited to answering explanatory 'how', 'what' or 'why' questions, and a central feature is the use of triangulation of data sources to gain a multi-perspective account (Yin, 2009). Case studies are more commonly associated with qualitative research methods, typically including interviews and observations, although a wide range of methods can be used, including quantitative methods (Merriam, 2009).

This study uses a particular type of case study to answer the research question: an ethnographic case study. Ethnography emanates from anthropology, although it has a long history across other disciplines, including the social sciences (Hammersley & Atkinson, 2007). It has been described in various ways and there are currently no agreed criteria for defining it (Vindrola-Padros & Vindrola-Padros, 2018). Brewer (2000) describes ethnography as the study of people and cultures within their real-life setting; the researcher systematically collects data by directly participating in the culture, to portray an in-depth account of everyday life. Traditional ethnography involves the researcher 'immersing' themselves in the culture through intensive fieldwork and building relationships with participants. Observational methods often form the basis for ethnographic research, usually in combination with other methods

such as interviewing and documentary analysis (Brewer, 2000). Although ethnographies are often studies of a certain case, ethnography is principally defined by its methodology and methods. In contrast, case study research is not defined by a methodology and therefore does not have to be ethnographic (O'Reilly, 2009). For example, Yin (2009) takes a scientific approach to case study research, aligning more with a positivist stance and prioritising concepts such as generalisability of findings.

Ethnography was chosen because it was the most suitable method for answering the research question. I wanted to conduct a rich, meaningful, in-depth piece of research that captures the complexities of providing child psychotherapy services in a children's social care environment, and the social processes that shape service delivery, from the perspectives of different participants (Hammersley & Atkinson, 2007). This is aligned with the 'thick description' utilised in ethnographic research (Geertz, 1973), whereby the researcher's description of the culture under study goes beyond the 'facts', and includes context, analysis, and interpretation as a means of understanding the behaviours observed. Ethnography also engages with social theory, to go beyond description and take an interpreted account, including the use of reflexivity (Vindrola-Padros & Vindrola-Padros, 2018). In this study, arguably a qualitative interview study could have been conducted as a means of answering the research question. However, I wanted to use observation as the main method, to access behaviours that participants were not consciously aware of, and to observe the interactions that occurred between participants in the setting.

Hammersley and Atkinson (2007) argue that ethnography has a 'funnel' structure, in which the research questions and focus of study are progressively honed over time. For example, as fieldwork progresses, initial ideas may be discounted if they are not supported by the fieldwork findings, or the research focus may change directions as emerging routes arise. Typically, data collection in ethnography is conducted over long periods of time, sometimes spanning several years, however recent research using short-term, rapid, or focused ethnographies argues that rich data can still be collected in shorter timeframes (Vindrola-Padros & Vindrola-Padros, 2018). Participants in this study were observed over a period of several months, which was in line with the analysis method (grounded theory, further details under section 5.3.6.1), as theoretical saturation had been sufficiently reached by the end of data collection. To mitigate a potential loss of richness in the data from

observing participants over a shorter time period than traditional ethnographies, several characteristics of short-term ethnographies were employed, namely: a focused research question, in which certain areas were prioritised; sampling on different days and at different times; capturing a range of participants' views; triangulation of data sources (Vindrola-Padros & Vindrola-Padros, 2018).

5.3.2 *Selecting the case / setting*

The setting was an inner-city based specialist LAC CAMH service, comprising two child psychotherapists, a psychiatrist and a psychologist; located within a social care office. A detailed description of the research participants can be found in section 5.3.4.

This service was purposively sampled, for the following reasons:

- a) A member of the team had been interviewed in study 2. As a first stage, all participants in study 2 were asked if they would be potentially willing to take part in a further, more in-depth study. Two participants agreed, and the settings in which these child psychotherapists were working were initially reviewed based on their ability to take on the research imminently (one participant led consultative group work but was not running any groups in the near future). Furthermore, it became apparent during this process that the child psychotherapists' roles in the chosen team had been changing in response to local authority requests over recent years and was therefore an exemplary site to explore child psychotherapy operating in a setting with different agencies and potentially different agendas.
- b) Given the findings from studies 1 and 2 (that child psychotherapists support children in local authority care in a number of non-traditional settings, not just mental health settings, as well as the tensions in a child psychotherapists' role working with the professional network), the site was selected because child psychotherapists were based within a social care team, offering a combination of direct work and consultation, and the opportunity to understand how the tensions identified in the previous study might play out in a social care setting.
- c) Of pertinence to the research topic, the service had been going through a process of transition over recent years, including the role of the child psychotherapists – with an increased emphasis on direct work with children, and reduced consultation work

with professionals (this will be described in more detail in section 5.3.4). This makes it a valuable case study to explore differing and evolving views on the role of child psychotherapists in work with children in local authority care.

The generalisability of the study's findings will be considered in the discussion section; that is whether the findings can be generalised to settings wider than the one under study. As statistical generalisation is not appropriate in this qualitative piece of research, Yin's (2009) concept of analytic generalisation is used as a criteria for assessing generalisability. With analytic generalisation, the researcher considers the extent to which the analysis and understanding gained from the research can be explicated to wider settings.

5.3.3 Ethical considerations, gaining access, and participant recruitment

Ethical approval was provided by the UCL ethics committee (Project ID: 8293/003, see Appendix 11). Given that the child psychotherapists worked in an NHS CAMHS team based in a social care setting, approval was then sought from the NHS Health Research Authority (HRA; IRAS number: 227718) and the local authority. The NHS approval was a two-stage process in which ethical approval was firstly gained from the national body, the HRA (see Appendix 12), and then local approval from the NHS Foundation Trust, who confirmed their capacity and capability to take on the research (see Appendix 13). Participant information sheets and the consent form can be found in Appendices 14-15.

Gaining access to the people and places under study is a key component of ethnographic research that has to be negotiated carefully (O'Reilly, 2009). In the first stage I had preliminary meetings with the child psychotherapists in the LAC CAMHS team, to discuss study ideas and ways of gaining access to the site. After developing the research proposal, ethical approval was sought as per the process outlined above. Local authority approval was given by the senior social work managers in the service, who then put me in contact with the team managers of the Child Looked After and Leaving Care team (hereafter referred to as CLA and Leaving Care team), who operated within the setting. Although the local authority was happy for the research to be conducted, the senior managers had some reservations concerning

the confidential nature of their work with children and families. I therefore had to negotiate access carefully (O'Reilly, 2009) and put in place measures to alleviate their concerns (in particular, the introduction of an 'opt-out' letter to families accessing the service), which are discussed below.

The ethical considerations relevant to this study are participants' informed consent, right to withdraw, confidentiality and anonymity, as well as the confidentiality of families accessing the service. Informed consent was sought from all members of the LAC CAMHS team and the social care team prior to the observation period commencing. They were provided with an information sheet, which informed them of the nature of the research and what participation involved. They were given an opportunity to ask questions before signing a consent form.

For the social care team, I initially emailed the participant information sheet to the team's deputy manager and asked them to cascade it around the team. I then attended their team meeting to present the study information in person. To give them time to digest the information and respond with further questions, I returned to the office around a week later to sign consent forms. This process was more problematic than expected because on the day of signing consent forms, I found that many of the team were not aware of the study because they had not been in attendance at the team meeting the preceding week. Study information therefore had to be provided individually again to different team members. Furthermore, it became apparent during this visit that the office had many staff and visitors who were not part of the social care team. This raised an ethical issue about conducting observational research in a setting where not everyone had given informed consent to being observed (Dingwall, 1980). On speaking to my PhD supervisor we agreed that in order to mediate ethical considerations around this, I would seek consent from all social care team members who were present on that day and then check with the deputy manager whether there were any remaining members who had not signed consent forms. Once the observations started, if the child psychotherapists were approached for a consultation by a professional I did not recognise, I asked them if they were aware of the study, explained my presence and sought verbal consent. I signed a consent form with them after the consultation had taken place. This process was undertaken to lessen my intrusion on the consultation as much as possible. This process was also adopted when attending professionals' meetings with the child psychotherapists, when there were education and / or health professionals in

attendance from the child's care network. In general, I found professionals to be amenable to the research, and I did not encounter any refusals from consent I sought 'on the spot'.

Another ethical issue I gave consideration to was the confidentiality of service users and their families. Although details of individual cases and families were discussed by participants during observations, they were not asked to provide any identifying or personal details that would breach confidentiality. Personal details of service users were not recorded in observation notes. Furthermore, families accessing the CAMH service and / or Children's Services, whose cases might be discussed during consultation sessions during the observation period, were sent a letter and information sheet advising them of the study and giving them the option to 'opt-out' of their family's details being discussed during observed consultations. Families were asked to return a signed opt-out form prior to the study commencing (see Appendix 16). Again this process was more problematic than anticipated: the child psychotherapists advised there were many families for whom sending such a letter was not appropriate, for example to young people who were struggling to engage with the service, and they did not want this to be further barrier to engaging. For such families we agreed that should their case be discussed during an observed consultation session, the professionals would anonymise their personal details. We also agreed that they could ask me to pause the observations at any point should they need to discuss confidential details of a family, although this situation never arose. This process was not ideal in that I was 'impacting' on and altering their usual practice, however it was a pragmatic solution to the ethical dilemma.

For ethical reasons, therapy sessions with children were not observed. The local authority did not agree to children or young people, their families, or foster carers being interviewed. The possibility of conducting further studies incorporating the views of foster carers will be discussed in the discussion section.

Another ethical issue I considered was the confidentiality and anonymity of the research participants. Participants' personal information was collected at the point of consent (for example, their role in the service) and stored on a password protected computer file. To maintain anonymity, participants were assigned an ID number (for example, social workers were assigned SW1, SW2 etc) that was used in interview transcripts. No identifying details were recorded in the observation notes, and any identifying details emerging during audio recorded interviews were removed

during transcription. Observation notes and interview transcripts were kept in password protected files on a password protected computer. The two child psychotherapists in the study were assigned the pseudonyms Alice and Mia.

5.3.4 *Participants and teams operating within the setting*

This section describes the participants in detail, including the characteristics, make-up, and everyday life of the teams operating within the setting. This is in keeping with ethnographic research (Whittaker, 2014); the aim is to provide context for understanding the subsequent analysis of participants' behaviours. A description of the setting itself can be found in Appendix 17.

5.3.4.1 LAC CAMHS team.

The LAC CAMHS team was made up of two child psychotherapists, a psychiatrist and a counselling psychologist. The team's remit was to provide mental health services for children and young people looked after up to the age of 18, although they also worked with children transitioning to adoption and could stay involved for up to a year post order.

The services provided by the team were: individual therapy to children and young people; consultation to, and network meetings with, the professional network around the child; and training with professionals and foster carers. They also provided supportive therapeutic work to foster carers directly, in circumstances when young people were difficult to engage in therapy or they did not want another new professional in their life. Finally, they provided 'anonymous' consultations, consulting with a professional about a child who was not an open case to the team, and therefore not recording the personal details of the child during that consultation.

Three of the four team members (including both child psychotherapists) worked part-time, over different days, ensuring there was always a minimum of two team members in at once. All team members were in the office on Fridays, which was when they all came together for their two-hourly team meeting. During their working hours, the team were often out of the office, visiting families or attending meetings with professionals. The child psychotherapists reported that they held the majority of their therapy sessions at the nearby mainstream CAMHS office,

particularly with younger children, as it was 'more set up for them there' (interview with Mia, 08.11.19), with more toys and rooms designed for therapeutic appointments.

In interview, the social care Service Manager described the evolution of the LAC CAMHS team over a 20-year period, initially brought in following the Quality Protects initiative (Department of Health, 1998), as a means of better access to a service supporting children in care's emotional health and wellbeing. However, cutbacks to local authority funding from 2012-2015 resulted in the loss of some non-statutory support services and provisions. For the LAC CAMHS team, this meant the loss of some clinical posts, including their Team Manager, as well as the withdrawal of administrative support. As such the team had been reduced from 7 posts to 4 posts over a period of several years. The remaining team members were all employed on the same NHS salary banding. Without a Team Manager to provide supervision, the child psychotherapists received monthly supervision from an external, senior child psychotherapist, based at the local mainstream CAMHS office. The child psychotherapists reported to me that they had also faced a changing emphasis on their workload in recent years, with the local authority requesting more individual, therapeutic work with children and young people, and less emphasis on their consultation and training work with professionals and foster carers. In an interview with the social care Service Manager, he explained that this shift in emphasis stemmed from cutbacks to services and a lack of resources: 'given that resources are less, we want you to focus on the direct work' (interview with Service Manager, 14.11.19).

5.3.4.2 Children's Services – CLA and Leaving Care Services.

The service comprised: 1 Service Manager; 5 Deputy Service Managers; 17 social workers; 9 Personal Assistants (who worked with young people aged 18-25); and a small number of other practitioners, such as Senior or Specialist social work practitioners, students, and a social work assistant. They received administrative support from a small team of administrators.

The service carried out statutory functions in relation to the Children's Act 1989 and the Leaving Care Act 2000. The core duties included implementing and reviewing permanency and pathway plans for children in local authority care and

care leavers, undertaking statutory visits, promoting contact and ensuring all developmental aspects were met with a particular emphasis on placement stability, health and education outcomes. The service had a culture of participation and building relationships.

The local authority had encountered several changes over recent years impacting on its functioning and practice. Following a period of financial crisis several years previously, they had needed to re-design services to achieve savings and this included shared services with the neighbouring boroughs whilst maintaining sovereignty over its overall duties to its constituents.

The service had previously operated as two separate teams (a Child Looked After team who worked with children and young people up to age 18; and a Leaving Care Team who worked with young people age 18-21 (or 25 if in higher education)), based in different offices. Following the teams' merger, the CLA team gradually relocated over a couple of years to the current office, where the Leaving Care Team were based. This enabled the service to meet the needs of both the younger and older children and following a refurbishment and redesign of the building, which included a quiet room and a therapy room, the service fully located to the one building. This move also reflected a gradual aging of the children in local authority care and increase in the population of care leavers.

Another recent change was the embedding of systemic practice as a cultural norm across the whole children's services organisation. All staff had been trained in systemic thinking and practice, albeit to different levels. The Service Manager explained that it was in the context of the remodelling of social work practice in the wake of the Munro report (Department for Education, 2011). It reflected a shift from targets and assessments to relationship building, skilling workers up in an intervention that they perceived as effective in producing lasting change, thus reducing the number of referrals and children coming into care, thus representing cost effectiveness. As part of developing the workforce, the local authority recruited a number of systemic practitioners to work alongside and support staff in developing systemic skills. For this service it meant having a systemic clinician who was not limited to working with children and young people under age 18 and who undertook interventions alongside the practitioners. This contrasted with the LAC CAMH team, who worked independently with the children and could not accept referrals for young

people age 18+, and could only continue working with a young person who turned 18 by putting forward a case with commissioners to continue therapy.

A detailed description of the office environment within which both teams operated, and where the majority of participant observations took place, can be found in Appendix 17.

5.3.5 Data collection methods

Traditionally, participant observation is the main method employed in ethnographic research, alongside other methods including qualitative interviews and documentary analysis. Multiple methods are used to triangulate data. Table 12 provides a summary of the data collection undertaken during the fieldwork period. A more detailed description of each method, and the justification for these choices, is then provided.

Table 12

Summary of data collection

Data collection method	Number	Timescale
Participant observation and informal interviews	22 days	June – December 2019
Formal interviews:		
2 child psychotherapists	3	Autumn 2019 – Spring 2020
Social workers / Personal Assistants	8	4 prior to observation period, 4 during observation period
Social work managers	2	November – December 2019
Documentary analysis	4	During observation period

5.3.5.1 Participant observation.

Participant observation is used in ethnographic research to observe behaviour as it occurs naturally in a setting. It is a useful method of accessing behaviours that other methods (such as interviews) may not access so readily, for example, behaviours the participant is not consciously aware of, or for observing interactions between groups of participants (Whittaker, 2014).

During the observation period, I observed the services the child psychotherapists provided to professionals working with children in local authority care. This comprised sitting in the office alongside the child psychotherapists and observing their practice at their desks, and whilst conducting 'informal' consultations and interactions with social workers, such as conversations in the corridors or across desks. During these observations, as the office was open-plan I sat at whatever available desk was nearest to the CAMHS team and varied my location on different days to observe different outlooks of the office. Furthermore, I observed the weekly two-hourly CAMHS team meetings, an opportunity for the team to come together to discuss their high-risk cases, new referrals, and other matters as necessary. The second hour of the meeting was on occasion used by the social care team to access advice and consultation; usually this was in the form of one consultation per week, with a social worker having a one-hour slot.

In addition to office observations, I accompanied the child psychotherapists to external meetings, such as network or professionals' meetings, held at various locations including local schools or council offices. The return walk to the main office gave me an opportunity to informally interview them about what had just taken place in the meeting. This approach draws on the recent emergence of 'mobile' ethnographies, in which the researcher participates in the participants' patterns of movement, for example walking with them as they go about their daily activities (Sheller & Urry, 2006). The practice of mobile ethnographies has been used and described by several researchers in the social work literature (e.g. Ferguson, 2018), and also seemed appropriate in this context as the child psychotherapists were often working out of the office.

In total, 22 observation days were conducted between June and December 2019. The observations were quite 'part-time', typically conducted one to two days a week, however this mimicked the working practices of the child psychotherapists themselves, who also worked in their role two days a week. There were also periods

of several weeks in which no observations were conducted, as during this time I focused on analysing the data in order to inform further data collection, in line with recommended guidelines for ethnographic case study research (Beebe, 2014). Observation days varied in length depending on the child psychotherapists' schedules, however typically they were conducted from 9.30am to 4.30pm. Most observation days took place on Thursdays and Fridays, when the child psychotherapists were in the office, however I also conducted office observations on days they were not in, to observe the atmosphere when they were not present.

In terms of my observational stance, participant observation has been defined differently by researchers (O'Reilly, 2009). Gold (1958) distinguishes four levels of researcher participation in ethnographic research, ranging from the 'complete participant', who is involved as a full member of the culture, to the 'complete observer', whose role is to solely observe and not participate (although some ethnographers argue that there is always some degree of participation in the setting). In this study, my role was more of an observer than participator, whilst acknowledging that inevitably there was some degree of participation in the culture. Therefore, my role was made overt to participants and there was some interaction with them; as an example, I talked to them in the kitchen while making coffee. However, my primary focus was as a researcher and observer (Angrosino, 2007). I view this as being in line with Spradley's (1980) concept of 'moderate participation', which Dewalt and Dewalt (2010, p.23) define as 'when the ethnographer is present at the scene of the action, is identifiable as a researcher, but does not actively participate or only occasionally interacts with people in it.'

During observations, I was mainly sitting quietly in the room using pen and paper to jot down key words, or drawings of the setting. I felt able to do this both during meetings and informal office consultations because it became clear from the first day of fieldwork that the child psychotherapists also took notes during consultations and meetings, therefore it did not feel out of place for me to be doing the same. As soon as possible after the observation was completed, I expanded the observation notes and typed them up. These 'field notes' were the primary means of capturing information from observations. This process was chosen because a) noting key words during observations rather than writing continuously ensured I was limiting my obtrusiveness to participants, b) I was starting the analysis process in parallel to data collection. By expanding my notes, I was familiarising myself with the data and

began the coding process at the time of typing notes up. Furthermore, this meant that analysis was an iterative process, to inform additional data collection (Beebe, 2014).

The field notes were organised as chronological, daily notes. A proforma was created to record the daily notes, which contained the following headings: description of activity (information on the physical setting, sensory perceptions, participant activity and interactions with others, and brief quotations or 'insider' language); reflections (thoughts, ideas, insights into what I had observed, and any impact I perceived to have had on the setting); emerging analyses (potential questions or lines of enquiry to pursue); and future actions. I also kept a data log to record the dates, times and descriptions of data collection activities. Finally, I kept a research diary in which I recorded a personal account of my feelings, thoughts, and reactions to participants and the setting (Dewalt & Dewalt, 2010).

During observations, I kept a fairly open stance to observing whatever was happening in the environment around me, whilst keeping the research question in mind. During quiet periods in the office, when people worked in silence at their computers, I used the time to write notes on my sensory perceptions of the environment, for example my visual perceptions, the layout of the space, sounds and smells in the environment.

Following observations, I often talked to participants about my observations and asked them additional questions. These 'informal' interviews are typical of ethnographic research (Spradley, 1980). For example, following the weekly CAMHS team meeting, I often had a debrief with the child psychotherapists about what had happened during the meeting. I also conducted informal interviews of the other clinicians in the CAMHS team, and members of the social care team. These informal interviews were recorded in my notebook as field notes.

Although some researchers argue that an inherent disadvantage of observations is that participants behave differently when being observed (Patton, 2002), by using observations as my main method of data collection, I hoped that participants would become used to my presence, enabling me to 'merge quietly into the background' (O'Reilly, 2009, p.20). Furthermore, the observations were used to inform the development and focus of my formal interviews, the majority of which were conducted as the research progressed.

Participant observations ended once 'theoretical saturation' had been sufficiently reached (Charmaz, 2006). Further details of theoretical saturation are provided under section 5.3.6.4.9.

5.3.5.2 My presence in the field during participant observation.

A key component of ethnographic research is the researchers' reflexivity, that is, consideration of how the researcher themselves participates in the production of knowledge (Vindrola-Padros & Vindrola-Padros, 2018; further details on reflexivity can be found under section 5.3.6.5). One element I considered in terms of my reflexivity was how my presence impacted on participants' behaviours, and therefore may have influenced what I observed and learnt from the setting.

It is difficult to say exactly to what extent my presence affected participants, although inevitably my very presence impacted on the office dynamics and potentially resulted in participants modifying their behaviour. In general, I felt that people were very open, candid, and honest around me, and I think that being able to physically sit at a desk (rather than sitting perhaps more obtrusively in the centre of the office with a pen and notebook) helped me to merge into the background. The open-plan nature of the office also benefitted me in terms of being able to observe numerous conversations and interactions between participants, while being sat unobtrusively behind a desk (Pithouse, 1987; Scourfield, 2003). In an effort to make my presence less conspicuous, I joined in with social conversations, and when asked, disclosed details of my personal life. Inevitably after being in the field for some time I built a rapport with participants, particularly those in the CAMHS team who I worked with most closely. As an example, after attending several of the weekly CAMHS team meeting, Alice started adding my name to the meetings' minutes – she smiled at me while saying my name was on record now. The child psychotherapists also introduced me to other people in various terms that I think were intended to both make me feel included, and put others at ease about my presence (I was introduced with terms such as 'the CAMHS researcher' and, jokingly said, their 'sidekick'). I did not try to hide my notebook and there were even a couple of occasions when participants jokingly asked me to recall from my notes something that had been said earlier in the day. There were a few instances in which participants stopped what

they were doing, unprompted, to explain something to me. There were other instances whereby participants commented on the potential impact of my presence; for example, after a professionals meeting in which a social worker said she appreciated having the space to think as it felt like she was 'sharing the emotional load', Alice later commented to me that 'perhaps she just said it because you were there'.

5.3.5.3 Interviews.

Interviews were used as they allow participants an opportunity to provide understanding and explanations of the observations (Spradley, 1980). As already stated, I conducted informal interviews on a daily basis as part of my observations. More formal interviews were also conducted; these were planned in advance, took place in a separate room away from other staff in the building, and were recorded using a Dictaphone and transcribed. Although I describe them as 'formal' interviews in this section – to distinguish them from the everyday conversations which formed part of my daily fieldnotes – in fact these interviews were also quite informal and conversational.

Prior to commencing participant observations, I conducted four of these more formal interviews with social workers in the team. The purpose was to gain an understanding of social workers' views and perceptions on their work with the child psychotherapists, primarily on the nature of their consultation work. Conducting these interviews prior to the observation period allowed me to ask naïve questions about their working relationships with the child psychotherapists, as I had not gained my own views and perspective from participant observations at that point.

Nine interviews were conducted during, or after, the observation period. Interviewees and interview questions were chosen as a means of achieving theoretical saturation. Further details of interviewees and interview questions is provided under the analysis section, 5.3.6.

5.3.5.4 Documentary analysis.

As part of theoretical sampling (see section 5.3.6.4.6), several policy documents were read. These documents were suggested by the social care Service Manager, to inform my understanding of the policies which the social work team operated under,

namely: The Quality Protects documentation (Department of Health, 1998); the Munro Report (Department for Education, 2011); the Focus on Practice initiative (Cameron et al., 2016); and the local authority's most recent Ofsted report, published during the observation period. I did not conduct any formal analysis of these documents, such as coding. Instead I used their content to inform my understanding of the wider context within which the LAC CAMHS and social care teams operated.

While conducting general office observations, I also read service structure documents that were pinned up on the walls or on desks. Again, I used these documents to inform my understanding of the wider service structure within which the teams' operated and recorded aspects of the documents in my field notes (without recording the personal details of staff).

5.3.6 Data analysis

Data analysis in ethnography has been described differently by researchers, perhaps reflecting the fact that there is no 'one size fits all' approach to analysis. Although in some respects, analysis follows traditional principles of scientific research (i.e. collecting data, analysing data, disseminating findings), analysis has been described as a 'spiral' approach (O'Reilly, 2009), or of having a 'funnel' structure (Hammersley & Atkinson, 2007). This essentially means that analysis is an iterative process, often used to inform theory development and subsequent data collection, and therefore occurring concurrently to data collection. For example, as themes start emerging from the analysis, then further, more direct interview questions based around these themes can be developed. Furthermore, the research should be increasingly honed and focused as it progresses.

Some ethnographers argue that analysis is not a distinct stage of the research process and begins as early as the initial stages of formulating the research aims, before fieldwork has even commenced (Hammersley & Atkinson, 2007). Other argue that it begins at the point of expanding and writing up the daily fieldnotes; Dewalt and Dewalt (2010, p. 166) state that 'even when the time difference is small, say several hours, the observer, now recorder, has already begun to evaluate and integrate the observations into the whole fabric of the fieldwork experience.' I certainly found this

myself, as the process of typing up daily field notes allowed me space to reflect and form initial thoughts on the observations.

Given this flexibility, the analysis method I chose was grounded theory (Glaser & Strauss, 1967). This method is compatible with the aims and intended product of the research, which was to develop a theory of how child psychotherapists function within a multi-disciplinary CAMHS team in a children's social care setting. Grounded theory is also well suited to studies investigating social processes which have previously received little research attention, as was the case in this study. Furthermore, there is much overlap between the key characteristics of ethnography and grounded theory studies, including the iterative process of data collection and analysis. Several grounded theorists have argued that grounded theory can be beneficial for focusing ethnographic research, therefore making it an appropriate method to choose (Charmaz & Mitchell, 2001). Further justification of the reasoning for choosing grounded theory will be provided in section 5.3.6.2, 'grounded theory and ethnography', however I will first describe the key features of grounded theory as a method.

5.3.6.1 Grounded theory.

Grounded theory is a systematic, yet flexible, research method used to construct theories through the iterative process of collecting and analysing qualitative data, resulting in theories that are 'grounded' in the data themselves (Charmaz, 2006). Founded by Glaser and Strauss in 1967, the original grounded theory was conceptualised in the post-positivist paradigm, taking an objectivist stance by assuming that the researchers' adoption of systematic analysis principles will result in the 'discovery' of an objective theory. Since its original conception, grounded theory proponents have diverged into several distinct applications of the method, including Glaser's (1992) 'classic grounded theory', Strauss and Corbin's (2008) 'basics of qualitative research', Clarke's (2005) 'situational analysis' and Charmaz's (2006) 'constructivist grounded theory'. Despite these different variants, all grounded theory studies contain a set of fundamental principles which Charmaz (2006, p.2) refers to as 'guidelines' rather than 'formulaic rules'. The shared commonalities of grounded theory studies are as follows:

1. 'Simultaneous data collection and analysis

2. Pursuit of emergent themes through early data analysis
3. Discovery of basic social processes within the data
4. Inductive construction of abstract categories that explain and synthesise these processes
5. Integration of categories into a theoretical framework that specifies causes, conditions and consequences of the process(es).'

(Taken from Charmaz & Mitchell, 2001, p.160).

In this study I chose to use Charmaz's (2006) constructivist grounded theory. Constructivist grounded theory assumes some of the original ideas of grounded theory's proponents, namely taking an inductive, emergent, comparative and iterative approach, as well as emphasising action and meaning. However, it rejects the positivist notions of an objective external reality and researcher, and instead argues that social reality is constructed. From this assumption, it therefore follows that the researcher's position and perspective form a part of constructing social reality (Charmaz, 2014). By taking this stance, I acknowledge that my analysis and resulting theoretical framework is an interpretation of the setting and behaviour I studied, constructed from my own perspective, past experience and interests, my interactions with research participants, and the research participants' own meanings and experiences (Charmaz, 2014).

Constructivist grounded theory was chosen because it fits with the epistemological assumptions of ethnography, which is described under section 5.3.6.3.

5.3.6.2 Grounded theory and ethnography.

There is an inherent tension between grounded theory and ethnography because ethnography involves a detailed, rich description of a culture, and focuses on the importance of culture for interpreting meaning (Barnes, 1996). In contrast, grounded theory methods focus the researcher on theory development (Charmaz & Mitchell, 2001). Despite this tension, Charmaz and Mitchell (2001) argue that it is not an incompatible one, and that grounded theory can be a useful and beneficial analysis method for ethnographers. Grounded theory can be used as a means of guiding and focusing ethnographic fieldwork to make it more succinct, as well as systematically managing the large volumes of data collected. It can also help to overcome some

problems associated with ethnographies, such as long, unfocused fieldwork. Furthermore, grounded theory moves ethnographic research beyond thick description and into theoretical interpretation by raising description to more abstract, conceptual categories (Charmaz, 2006; Charmaz & Mitchell, 2001). Grounded theory's emphasis on comparative methods and going back and forth between data and analysis is useful for allowing ethnographers to compare data with data from the outset, compare data with categories, and show relationships between categories (Charmaz & Mitchell, 2001). Charmaz (2006) argues that a grounded theory study takes a different form and perspective to other ethnographies, giving more attention to phenomenon or process and actions than to describing the setting.

5.3.6.3 Epistemology.

As this study is an ethnographic, grounded theory study, the epistemological assumptions of ethnography and Charmaz's (2006) grounded theory were used. Epistemological assumptions arising from ethnographic research are that knowledge is co-constructed intersubjectively through the perceptions and interactions that people make within settings (Brewer, 2000), including the researchers' interactions with participants through their immersion in the environment. Ethnography has a focus on the emic; understanding knowledge from the perspective of the participants under study.

Symbolic interactionism is the theoretical perspective associated with constructivist grounded theory (Charmaz, 2014), and has also been associated with ethnography (Rock, 2001). Charmaz (2014, p. 262) defines symbolic interactionism as 'the theoretical perspective that views human actions as constructing self, situation, and society'. The assumptions underlying this perspective are that language and symbols are important in creating our actions and subjective meanings. A distinctive characteristic of symbolic interactionism is that people are active agents in interpreting and constructing their own situation, despite the existence of social structures. Symbolic interactionism emphasises the reciprocity of interpretation and action, thus arguing that we act in response to our view of the world, and this may affect other people's actions. The consequential impact of our, and other people's, actions may then lead us to alter our interpretations. This

perspective therefore assumes reciprocal processes occurring between individuals, society, and the environment (Charmaz, 2014).

Charmaz (2014) draws on Blumer's (1969) hypothesis that human behaviour is formed from social interaction, which is a symbolic process and relies on shared language and meanings. Mead (1932) theorises that language is important for developing our sense of self, as well as our social conduct within our communities. The possession of a self dictates how we act towards our self and others. Charmaz (2014, p. 268) distinguishes two types of self within this perspective: self as a 'continually unfolding process' and self as a 'stable object', thus indicating that people have a relatively stable self-concept, but this is subject to fluid change and reconstruction.

An ethnographic study grounded in a symbolic interactionist perspective holds the assumption that knowledge production is a process or practical exchange (Rock, 2001). Thus, knowledge emanates directly from the researchers' fieldwork; the researcher remains open to learning about the social world under study, without taking anything for granted at the outset (Rock, 2001). In undertaking fieldwork, I was not a truly objective or naïve observer, despite remaining open to what I observed in the field. Inevitably I will have approached the research in a different way to another researcher, asking potentially different questions of participants, or being guided towards a different research focus. The practice of reflexivity was used to 'unpack' these assumptions (Rock, 2001). By adopting this perspective, I recognise that my fieldwork is interactive and interpretive; an ongoing and changeable process which is tentative and uncertain of the end product (Rock, 2001). Symbolic interactionism's emphasis on language means I paid particular attention to participants' language, as well as my own language and how it shaped what I asked.

Adopting this epistemological framework means I not only recognised my own interpretation of the phenomenon under study, but also acknowledge that participants were interpretive beings themselves. During fieldwork I entered a social world in which participants were already actively constructing their own social meanings and actions (Rock, 2001). The knowledge I gained from fieldwork was, always, secondary – my interpretations of other peoples' knowledge, meanings, and interpretations. Despite this, bringing an interactionist ethnographic perspective to the research allowed me to ask questions of participants about things that they may

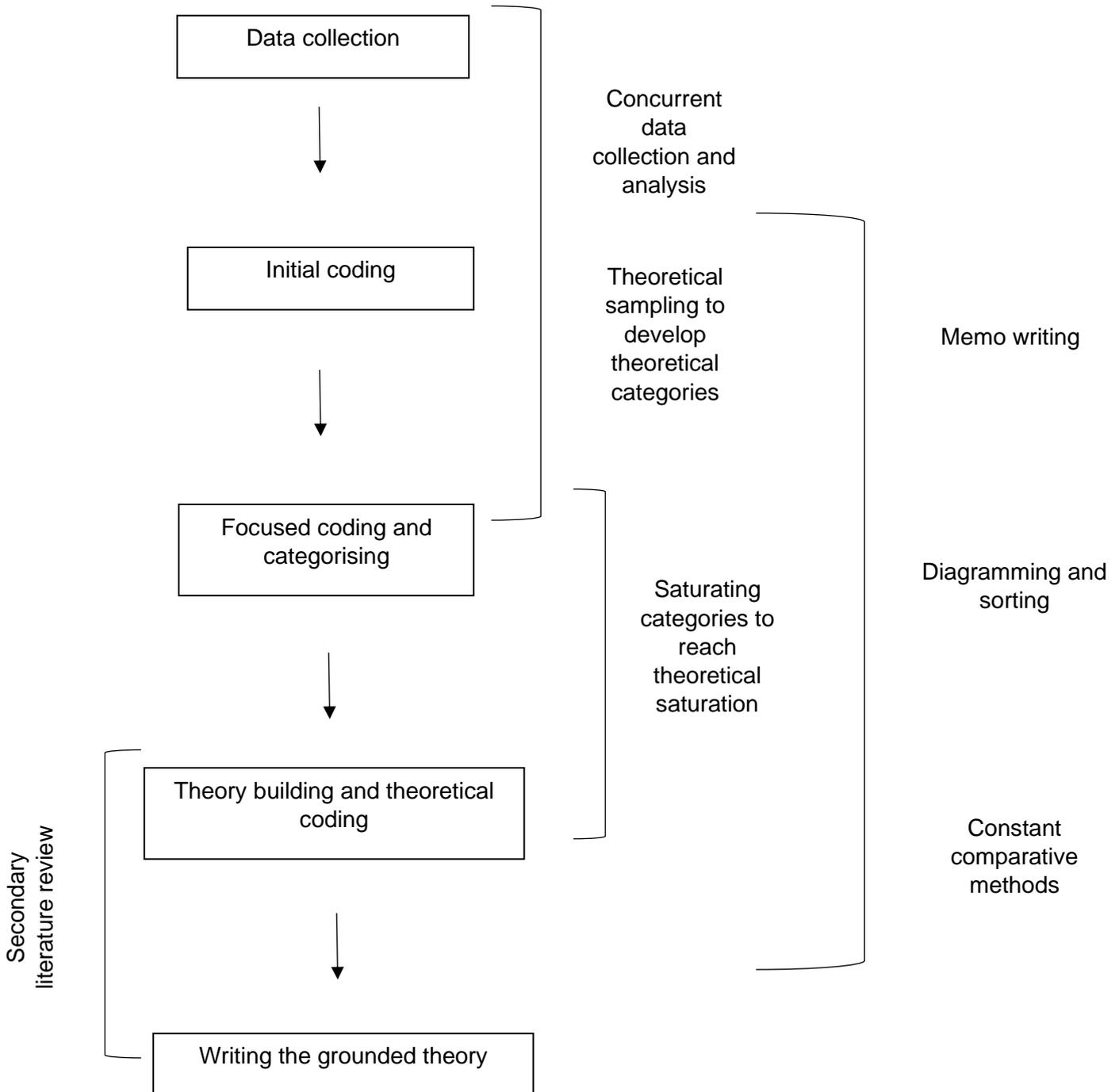
take for granted, or not perceive as interesting to pursue further (Rock, 2001). For example, I often asked quite simple questions about the content of therapy sessions with children and young people, or the child psychotherapists' consultations with professionals, which they may not have necessarily explained to me unprompted. Finally, by adopting this perspective, I acknowledge that there are limits to the knowledge I acquired during this study; despite reaching 'theoretical saturation' by the end of the study, the findings are inevitably bound temporally and contextually in what I happened to encounter at that particular time and place in the participants' lives (Rock, 2001). For example, I entered the field at a time of recent change and upheaval for the CAMHS team; had I conducted observations a year earlier or later, the working landscape, and the interactions between participants in the setting, may have been very different.

5.3.6.4 Charmaz's (2006; 2014) grounded theory process.

Figure 1 displays a visual representation of the data collection and analysis process. Although the process is described in a linear fashion in the following sections, the process is instead an iterative one, with movement back and forth between data collection and analysis (as seen in Figure 1).

Figure 1

Grounded theory analysis process. Adapted from Giles et al. (2016) using Charmaz's constructivist approach to grounded theory



5.3.6.4.1 Initial coding.

Coding was conducted using NVivo v.12, a qualitative data analysis software package that allows data to be organised, sorted, and managed (QSR International, 2021). Coding in grounded theory is defined as assigning labels to sections of data, in order to summarise and categorise it (Charmaz, 2014).

The first stage in coding is initial coding. In this phase the researcher assigns codes to each line or short segment of data. In keeping with grounded theory logic, the researcher adopts an open stance to exploring whatever theoretical possibilities arise from the data (Charmaz, 2014). Coding is inductive and therefore initial coding should stick closely to the data, rather than forcing pre-conceived ideas onto it. Glaser's (1978) proposition is that initial coding is conducted line-by-line, meaning each line of data is assigned a code. The benefits of line-by-line coding include sticking close to the data and breaking the data apart to analyse actions and events and look for patterns (Charmaz, 2014). However, Charmaz and Mitchell (2001) acknowledge that line-by-line coding is not always feasible in ethnographic research, due to large volumes of data that may include description of mundane activities.

In this study, where possible I allocated a short code to each line, that I felt best described and accounted for the data. My coding encompassed larger segments of data when I felt this was appropriate, for example when my observation notes described the physical layout of a space, or participants' more mundane daily activities. Initial coding was conducted early in the data collection process, thus conforming with a core tenet of grounded theory which is simultaneous data collection and analysis. This phase of coding was conducted quickly and spontaneously, as advocated by Charmaz (2014), to allow my thinking to be open and unencumbered by pre-conceived ideas. Most of the initial coding was done using gerunds (the verb forms of nouns, typically words ending -ing), which Charmaz (2014) advocates as a means of coding using processes and actions. Examples of coding using gerunds can be found in Appendix 18. Charmaz (2014) maintains that this form of coding keeps analytic momentum to the analysis, as opposed to assigning 'static' labels to 'types' of people. Coding using actions and processes also encourages the reader to analyse from the participants' perspective from the beginning of analysis (Charmaz, 2014). In vivo codes were used where they accounted for or captured something about the data.

Initial codes were, at first, provisional (Charmaz, 2014). As data collection progressed, more succinct, better fitting names were developed for the initial codes, and thus earlier field notes were recoded using these revised codes. An example of initial coding can be found in Appendix 18. The process of initial coding was useful in delineating codes that captured something meaningful about the data and could be raised to the level of focused codes. It also helped me to consider where data collection should be focused next (Giles et al., 2016).

5.3.6.4.2 Focused coding.

Focused coding is the second phase in coding, although the transition from initial to focused coding is not an entirely linear process (Charmaz, 2014). Focused coding involved raising some initial codes to a focused code when they captured something meaningful about the data, appeared frequently, or were linked to the research question. The purpose of focused coding was to synthesise larger portions of data in a more conceptual manner (Charmaz, 2014).

Once focused codes had been developed, I discussed them with my PhD supervisor during supervision. These codes were again tentative, with many revisions throughout the data collection and analysis process. The entire dataset was recoded using the focused codes. An example of initial coding moving to focused coding can be seen in Appendix 18.

5.3.6.4.3 Constant comparison.

Glaser and Strauss (1967) first described the constant comparison method, which forms a key tenet of grounded theory, and is used at each stage of the analysis process to create analytic distinctions. In this study, constant comparison was used throughout all stages of the analysis process to identify similarities and differences in the data, and to refine codes and categories. The comparisons included:

- Comparing events and actions on different observation days, and at different times and places. This included routine daily activities, which were compared over different days and times.
- Comparing participants' views and events within the same interview, and within different interviews.

- Comparing perspectives and actions of different research participants (child psychotherapists; other CAMHS team members; social workers; social work managers).
- Comparing codes with codes, categories with categories, and data coded under the same codes and category.
- Comparing the analysis with existing theoretical constructs in order to code theoretically (see section 5.3.6.4.8).

5.3.6.4.4 Memo-writing.

Charmaz (2014, p. 162) describes memo-writing as the 'pivotal intermediate step between data collection and writing drafts of papers'. Memo-writing enables the researcher to develop their ideas, critical thinking skills, and reflexivity, while staying close to the data (Charmaz, 2014). Memo-writing is done early in the research process, enabling the researcher to analyse and progressively refine codes in subsequent memos, as well as increasing the level of abstraction of their thoughts.

In this study, memos were written on the focused codes. Memos were written spontaneously and in a free-flowing way, quickly jotting down ideas, thoughts, comparisons, and questions to pursue in future data collection (Charmaz, 2014). Throughout the analysis process, I returned to my memos and revised earlier drafts, eventually sorting and resorting them into an order that made sense for the emerging theory. Early memos were discussed with my PhD supervisor, which helped with the revision process. Memos enabled me to raise focused codes to conceptual categories, and to define the properties of the categories (Charmaz, 2014). Examples of memos can be found in Appendix 18.

5.3.6.4.5 Development of categories.

Glaser and Strauss (1967, p. 37) define a category as a 'conceptual element in a theory'. Focused codes that had higher conceptual value were raised to categories. Categories coalesced a number of focused codes. An example of a category and which focused codes it subsumed is provided in Appendix 18. After developing tentative categories, the entire dataset was recoded using these categories.

Through memo writing and using the constant comparison method, I clarified the properties of each category, variations within it, and comparisons with other categories. This process also enabled the identification of gaps in the analysis (Charmaz, 2014), which were presented to my PhD supervisor to discuss further data collection required. Eventually, a core category was identified. The core category was chosen because it was central to all the other categories, accounting for and explaining them. It also occurred frequently in the data, explained variations in the data, and felt meaningful (Birks & Mills, 2015).

5.3.6.4.6 Theoretical sampling.

Theoretical sampling is a distinctive characteristic of the grounded theory process, with sampling geared towards theory development (Charmaz, 2006). This contrasts with other forms of sampling, traditionally used to define specific populations to study, often before the research begins. Theoretical sampling begins when the researcher has developed some tentative categories. Initially it can be used to delineate the properties of a category, to answer unanswered questions, and to check emerging hypotheses. Later it can also be used to saturate the properties of a category, distinguish between categories, and identify relationships between categories (Charmaz, 2014). After conducting theoretical sampling, the researcher returns to coding, and codes the new material using initial and focused codes.

In this study, theoretical sampling began once tentative categories had been developed. Through memo writing, I identified gaps in my understanding which required further sampling. For example, I realised that although I had observed social workers' practice for several months, I had not conducted many informal interviews with them, and my field notes largely reflected the perspectives of the CAMHS team. Through theoretical sampling, I therefore interviewed 6 social workers, Personal Assistants (who worked with young people age 18+), and managers, who worked alongside the child psychotherapists. I also conducted informal interviews during observation days, focused towards answering gaps in understanding. Furthermore, my observations became more focused, for example I observed several meetings between the LAC CAMHS team and the local authority clinical (systemic) team, geared towards understanding the implications of working in a setting with a cultural norm of systemic practice. Three interviews were also

conducted with the two child psychotherapists. As well as being used to saturate the properties of the categories, the final interview with the child psychotherapists served as a member-check (Charmaz, 2006), to ensure the categories resonated with their experience. A list of interview topics, covered during theoretical sampling, can be found in Appendix 18.

During theoretical sampling I also examined several social work policy documents (as described under section 5.3.5.4).

After each interview, the categories and their properties were revised, with further interviews being conducted until theoretical saturation was reached. The entire dataset was recoded using the final categories.

5.3.6.4.7 *Diagramming and sorting.*

Diagramming provided visual representations of categories and sub-categories, and relationships between them (Charmaz, 2006). Later, diagramming was used to reorder and redefine categories during the revision process (Giles et al., 2016). For example, through diagramming the initial tentative categories, an additional category was identified ('Having professional confidence in the child psychotherapist identity and role'), upon realising that this was a condition that permeated all the other categories. This was therefore made into a category into its own right.

Memos of categories were also compared with each other and sorted. This was done to integrate them into a logical order that made sense for the emerging theory.

5.3.6.4.8 *Theoretical coding.*

Theoretical coding was conducted after theoretical sampling. Theoretical coding is a more conceptual level of coding in which the researcher demonstrates relationships between the categories that were developed during focused coding (Charmaz, 2006; Glaser, 1978). In contrast to the data-driven initial and focused coding, theoretical coding involves imposing ideas and underlying logic from external, existing theories to the analytic process (Thornberg & Charmaz, 2014). Glaser (1978) specifies 18 possible 'coding families' that can be used as theoretical codes, although Charmaz (2006) urges caution in using these coding families to 'fit' the data.

During this stage, I examined the conditions under which each category occurred, consequences of the categories, variations amongst categories, and relationships between them. Theories of professional identity were applied as a theoretical code to the entire dataset, as this was most appropriate for the study's findings, and enabled me to specify relationships between categories using the underlying logic of the theories (see Discussion section for further information). By the end of theoretical coding, the categories had been developed into a substantive, integrative theory, from which hypotheses could be drawn.

5.3.6.4.9 *Theoretical saturation.*

Charmaz (2014, p. 113) defines theoretical saturation as occurring 'when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories'. Data collection therefore continues until the properties of the categories are saturated.

In this study, the core category had been developed after 22 observation days and informal interviews, plus 11 formal interviews. I then re-interviewed the two child psychotherapists on two occasions to fully saturate the properties of the categories. All data was recoded against the final categories, including searching for instances that were not explained by the theory. By the end of coding, no new focused codes were developed, therefore suggesting that the theory sufficiently accounted for all the data collected, and theoretical saturation had been achieved.

5.3.6.5 *Reflexivity.*

Reflexivity is a core principle of ethnographic research (Hammersley & Atkinson, 2007), which was practiced throughout data collection and analysis. Vindrola-Padros and Vindrola-Padros (2018; p. 327) define reflexivity as 'the authors' critical analysis of the position they occupy throughout the research process and how they participate in the production of knowledge'. In contrast to quantitative and positivist approaches, which focus on eliminating sources of bias where possible, qualitative approaches instead embrace the researchers' subjective position (Fook, 2001), while also adopting systematic means of ensuring the research does not merely reproduce the researchers' preformed ideas and preconceptions. Reflecting on the researchers'

background, experience, and values, among others, is an integral component of the ethnographic research process. Ethnographic research acknowledges that the researchers' findings are, always, interpretive, therefore engaging in reflexivity allows the reader to understand how the account may be filtered through the researchers own experiences, and to assess the extent to which it may reflect participants' own experiences (O'Reilly, 2009).

During the study, I considered the elements of my own background and experiences that were relevant to the research. I was acutely aware of my position as an academic researcher with a different professional background and 'culture' to the participants under study, namely mental health clinicians and social care staff. This position could be viewed as both a strength and a limitation. For example, it could mean that I was not as readily accepted as someone with clinical or social work experience; being viewed as an 'outsider' who comes from a detached, slightly protected, academic world compared to those who work on the frontline. To mitigate potential negative effects of this, I repeatedly made it clear to participants that I was there to learn about their culture and experiences. In contrast, this 'outsider' naivety was beneficial in allowing me to ask questions that an 'insider' would not necessarily think of asking, or about concepts that insiders take for granted (O'Reilly, 2009). For example, I could ask the child psychotherapists quite simple questions about what their therapy sessions involve, which perhaps a child psychotherapy trainee student would not think of asking. A further potential benefit of being an 'outsider' was that I did not foreclose my analysis too early.

Despite coming from a different professional background to the participants under study, there was an interesting tension because in a previous role I had worked for several years as an administrator in a children's social services department. This meant that I understood some of the 'language' used by social work teams, as well as their policies and procedures. I therefore approached this study with an understanding of some of the needs and presentation of these children and young people. During fieldwork I was conscious of the knowledge I had built during this role, and that it may lead me to not questioning things which I perceived to already understand. Having this awareness in mind, I tried to remain open to asking questions of participants about topics that I otherwise may not have challenged. I was also conscious of potentially being viewed by social workers as 'aligned' with the child psychotherapists' perspective, considering my access was

facilitated by them, and I was introduced using terms such as their 'sidekick'. Again, to mitigate any potential effects of this, I repeatedly reminded social workers that I was there to understand their perspective and experiences of working with the child psychotherapists.

I also considered my own preconceptions prior to commencing this study, including my knowledge of psychoanalysis. My background is in psychology and, prior to undertaking the doctorate, I had only a limited knowledge of child psychotherapy as a profession, and psychoanalytic theories. My doctorate was part-funded by the Association of Child Psychotherapists and therefore had a focus on psychoanalytic models of working with children in local authority care. My thinking and analysis of the data may therefore have been shaped by my relatively 'new' understanding of psychoanalysis, however I also feel this was a strength in allowing me to ask the child psychotherapists' detailed questions about their theoretical frameworks.

Whilst undertaking study 2 (see Chapter 4), I conducted a literature review of psychoanalytic perspectives on organisational defences against anxiety. I found this literature enlightening for understanding the potential ways that professionals working in this field may protect themselves against the painful nature of the work, which then may be replicated at an organisational level. I was conscious of this theoretical perspective whilst undertaking fieldwork in the current study and found myself on occasion interpreting some participants' behaviours in light of this understanding. This position was also aided by the child psychotherapist participants, who frequently used this framework to interpret the behaviour of social workers and other professionals in the child's care network. During fieldwork I found it useful to pay attention to the perspectives of other CAMH team members, who being from other disciplines, sometimes held differing perspectives to the child psychotherapists on what may underlie behaviour.

Before fieldwork commenced, I also had some preconceptions (gained from study 2) about the potential tensions that may arise between a CAMHS team and social services team operating in the same setting. Again, these preconceptions could be viewed as both a strength and limitation. A positive is that they could be viewed as a source of theoretical sensitivity, which I used to give insight and meaning into the analysis (Giles et al., 2016). Theoretical sensitivity is a concept in grounded theory whereby the researcher is able to generate meaningful concepts

from the data, and separate relevant from irrelevant detail (Glaser, 1978). However, I tried to remain open to what I was observing in the setting without forcing my preconceived ideas onto it, and often tried to challenge my own assumptions by asking participants about concepts that I felt I already 'understood'.

Whilst undertaking fieldwork, I engaged in several methods of developing my reflexivity, to ensure that it informed the analysis but did not diminish the study's findings. I recorded my reflections in daily field notes and a reflective diary. I also engaged in reflexive discussion with my PhD supervisor during supervision. This helped me to identify aspects of reflexivity relevant to the research, and the potential impact on my interpretation of observations. For example, as fieldwork progressed, I found that I was potentially identifying with the CAMHS team during observations; spending so much time shadowing their practice meant I found myself prioritising their perspective over other agencies' perspectives, or on occasion, adopting their perspective as my own. Discussion with my PhD supervisor allowed me to return to the field with an awareness of this, to ensure that adopting the perspective of the CAMHS team did not detract from the views of other professionals in the setting, or indeed my own views.

Other sources used for developing my reflexivity included informal discussions with other PhD students, and more formal presentations. This included presenting my findings to a group of trainee child psychotherapy students. These discussions allowed me to hear the perspective of other people who were not so intimately involved in the research as I was, and for me to consider alternative explanations for my interpretations.

5.3.7 Promoting rigour and trustworthiness in the research

Lincoln and Guba's (1985) framework of four dimensions essential to promoting rigour in qualitative research was adopted in this study, namely:

1. Credibility – establishing that the findings are 'believable' or credible from the perspective of the study's participants.
2. Transferability – the extent to which the findings are transferable to other settings and contexts.

3. Confirmability – verifying that the findings are shaped more by the participants than the researchers.
4. Dependability – the degree to which the findings are consistent; if another researcher conducted the same study, they would have similar findings and interpretations.

Table 13 demonstrates the approaches used to promote each of these dimensions.

Table 13

Approaches used to promote rigour and trustworthiness in the research. Adapted from Whittaker (2014)

Criterion	Approaches used	How approach promotes rigour
Credibility	Use of ethnographic methodology and qualitative methods to address research question.	Methodology and methods match the research question and study aims.
	Research proposal examined by university ethics committee, NHS Health Research Authority, local authority, and PhD supervisors.	Research design and methods subject to scrutiny, which helped to address initial problems with the research and develop the data collection tools.
	Multiple data collection methods used.	Overcomes problems associated with individual methods, for example, observations allow researcher to access behaviours that may not be elicited through traditional interviews. Also provides a multi-perspective

account and allows for data triangulation (see below).

Observations conducted over several months and on different days and times.

Allows prolonged engagement in the setting, meaning that findings and interpretations are based on multiple observations, which have been conducted on different days to gain a detailed insight into participants' daily activities within the setting.

Fieldnotes written during observations, and then expanded on immediately after observations.

Ensures accurate records are kept.

Participants informally interviewed after observations, and formal interview schedules are informed by observations.

Formal, in-depth interview questions are focused on emerging insights and allow participants to explain the observations. Informally interviewing participants immediately after observations allows them to expand on and contextualise the observed behaviours.

Purposive sampling strategy for formal interviews undertaken during theoretical sampling.

Ensures different perspectives of participants in the setting are captured.

	Digitally recorded formal interviews.	Ensures accurate records are kept.
	Data analysis discussed with PhD supervisors.	Provides different perspectives on the analysis.
	Triangulation of data sources during analysis and write-up.	Provides different perspectives on the analysis.
	Practice of reflexivity adopted.	Transparent approach to how my background, values and experiences have impacted on the research.
	Member check – feeding back the theory to the study’s participants. The study’s findings were presented both to the child psychotherapist participants, and as a formal presentation to the participating social care team.	Participants can feedback whether the theory feels meaningful to them and resonates with their experiences.
Transferability	‘Thick description’ of the setting, describing the context as well as behaviours observed.	Allows readers to determine the extent to which the findings are transferable to other settings.
	Presenting initial observations and	Gained feedback on the observations from trainee child

	emerging theory to a group of child psychotherapy students, all of whom were working in different settings.	psychotherapists working in different settings.
	Presenting the theory as a webinar to the members of the regulatory body for UK child psychotherapists.	Gained feedback on the study’s findings from child psychotherapists working in a range of settings.
Dependability and confirmability	Transparent approach to describing the development of the research, collection and analysis of data.	Provides an ‘audit trail’ of decisions and research processes, including a rationale for the approaches adopted. Also allows other researchers to evaluate the quality of the research.
	Practice of reflexivity.	Allows readers to judge the extent to which the findings and interpretations are shaped by the participants’ narratives rather than the researchers’.

5.4 Findings

This section presents the findings of the study. The core category, *Integrating professional identities* was developed because it was central to all the other categories, explaining how the child psychotherapists functioned and positioned themselves within both a multi-disciplinary team and a multi-agency setting. The main finding is that the child psychotherapists balanced three elements of their professional identity in their role in this setting. Their role involved engaging in a

variety of processes, which ultimately aimed to place the child's emotional and psychological life, as they understood it, at the centre of social cares' planning and practice. The child psychotherapists shifted between identities while engaging in these processes. The core category comprises several categories and sub-categories, which are detailed below.

5.4.1 Core category: *Integrating professional identities*

As depicted in Figure 2, analysis of the data suggested that the child psychotherapists managed multiple professional identities in this setting. Category 1 presents these three professional identities as a *discipline-specific identity*, *CAMHS team member identity*, and *professional network member identity*. Category 2 details the actions and processes the child psychotherapists engage in in their roles, namely *advocating the child's emotional and psychological life; attending to social workers' feelings and anxieties; investigating, and challenging, thinking and decision-making; and facilitating a sense of agency in social workers*. These processes, I argue, incorporate the three professional identities – while engaging in these processes, the child psychotherapists draw on and shift between their three professional identities. The third category, *Having professional confidence in the child psychotherapist role and identity*, is a condition for engaging in these processes and contributes to the child psychotherapists integrating their professional identities.

The core premise of the grounded theory developed in this study is that in their role in this setting, the child psychotherapists need to have integrated the three elements of their professional identity. The theory proposes that through their role in this setting, the child psychotherapists ultimately aim to place the child's emotional and psychological life, as they understand it, at the centre of social cares' planning and practice, making connections between the child's internal world and external world. I argue that there are instances of the child psychotherapists achieving this successfully. However, I also present instances of the child psychotherapists being unsuccessful at achieving this, demonstrating instances of how the setting within which they operate provides many uncertainties for their role, and at times limits them in achieving their intended consequences.

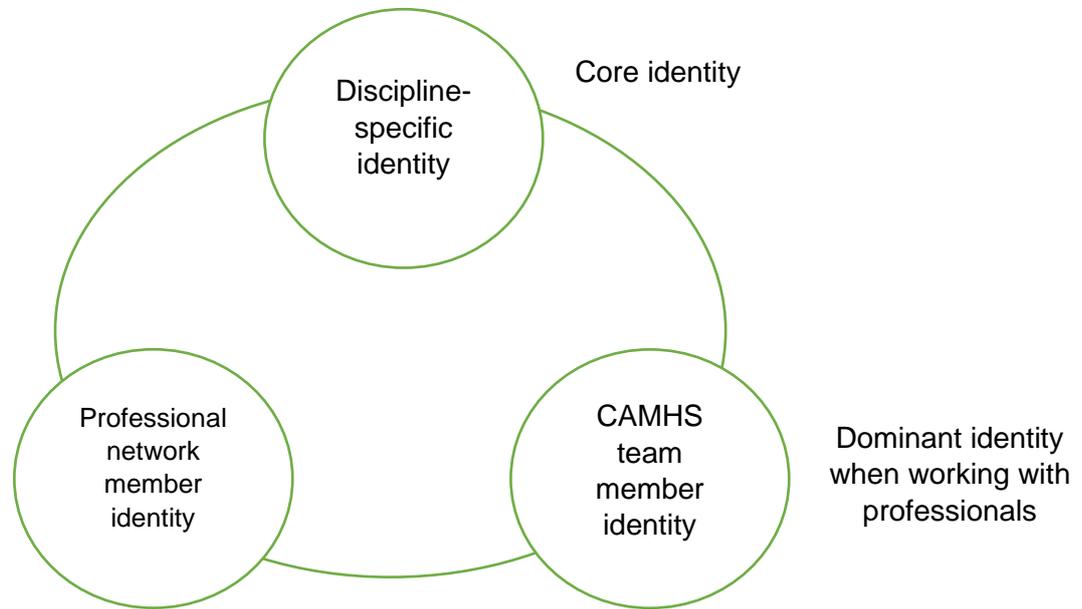
It is important to note that the theory focuses primarily on the child psychotherapists' work with the professional network around the child or young person, particularly with social care. Due to ethical constraints (as explained under section 5.3.3), the child psychotherapists' direct work with foster carers and children was not observed, nor were foster carers or children in local authority care interviewed. However, these aspects formed an integral component of their work, and will be discussed in the Discussion section.

5.4.2 Category 1: Child psychotherapists' multiple professional identities

The three professional identities (as shown in Figure 2) are presented as sub-categories, namely: *discipline-specific identity*; *CAMHS team member identity*; *professional network member identity*. This category will describe the characteristics of each identity and explore instances in which the child psychotherapists adopted a certain identity as their 'primary' identity.

Figure 2

The three professional identities adopted by the child psychotherapists



5.4.2.1 Sub-category 1: Discipline-specific identity: psychoanalytic child and adolescent psychotherapist.

The discipline-specific identity comprises instances in which the child psychotherapists primarily asserted their identity as a child psychotherapist, in comparison to their other professional identities. In interview, one of the child psychotherapists reported that their discipline-specific identity was most evident in their therapy sessions with children and young people, rather than their interactions with social workers and other professionals. She commented that had observations been conducted of therapy sessions, the differences between CAMHS disciplines would be quite apparent,

I think you would notice that when you’re working with somebody, you would get the difference. And I think that might be more striking between Alice and I, and [counselling psychologist]. The sort of questions you might ask, the way you might frame something, the way you think about something. I think we would probably be more thinking of the underlying unconscious dynamics, or

the kind of feelings that might be driving something, the anxieties and rejection etc. That might not be on the surface being said. And I think although [counselling psychologist] may be aware of those things he would say less about that. (Interview with Mia, 08.11.19)

Despite this, during general office observations, and observations of consultations with professionals, the child psychotherapists also asserted their discipline-specific identity outside the therapy setting. During general office observations, when the child psychotherapists were sat at their desks, field notes recorded that they often gravitated towards each other. This was demonstrated either by sitting together, or if there were no available desks for this, by having frequent conversations together across desks. These conversations were often case-related discussions about specific children or young people, but on occasion they spoke about psychoanalytic theories or practice. These conversations appeared to form a positive part of their identities as child psychotherapists, and were mainly spoken about with each other, rather than with others in the office.

Having two child psychotherapists in the team was perceived positively by both. Alice commented that having two child psychotherapists helped to 're-align' her during case discussions; 'Mia makes an observation and I feel my compass dial go back in the right direction' (Alice, interview 27.03.20). This metaphor appeared to describe their sense of psychoanalytic thinking as a compass, perhaps useful for when they get 'lost' in multi-disciplinary case discussions. They also perceived that having two team members from the same discipline enabled them to make connections between the internal world of the child, and the external world of their environment and professional network. Alice explained it as,

Quite often for each other, we'll have some thoughts, how to think about what the other one [other child psychotherapist] is talking about sort of as an internal picture or an internal situation, and not only as the external one. That one is feeling driven mad by or upset about. I just don't think there is anyone else on the team that would do that. They're just not there to make that shift. Sometimes you feel a sort of pull out a bit, or you drift out a bit, there's also a lot to take you out there because there's a lot of things that aren't going right, such as in a foster placement...there's just something sometimes really

helpful about the other person saying well I think this is, you know another way of thinking about this or what's also going on in the internal situation for the child...and then you sort of go 'oh well even though I can't do anything about what's going on there, I've got another way of thinking about what might be going on in the work with the actual child' (Interview with Alice, 08.05.20)

This demonstrates her perception that child psychotherapy is unique in making a 'shift' to the internal world of the child, that she indicates no-one else in the CAMHS team would do. Having two child psychotherapists enabled her to make – and hold on to – connections between the internal and external, therefore encouraging her to keep thinking in the face of very complex situations. Both child psychotherapists also commented that having two team members from the same discipline enabled them to think in creative and 'alive' ways and not get 'drawn back into concrete thinking' (Mia, interview 08.05.20), which they perceived professionals working in this field to easily resort to when feeling under pressure.

The child psychotherapists' consultations and conversations with social workers were also often informed by their theoretical framework, frequently around organisational defences against anxiety or splitting behaviours. An example is shown by field notes from a meeting the CAMHS team arranged with a newly formed social work team, responsible for working with unaccompanied asylum-seeking children and young people (UASC). The meeting's aim was to identify support the CAMHS team could offer to social workers working with this particular group of young people:

Alice says she is thinking about how the UASC social workers function as a team and don't replicate dynamics. She says they are listening to many stories of trauma and how do they keep listening without becoming defensive or splitting – she then rephrases this, saying 'without needing to protect yourself'. Alice says they need to ensure they are looked after as a team and that it is attended to, as in this type of work it is very common for people to go off sick or burn out (Field notes 09.08.19)

The above example demonstrates observations that the child psychotherapists' theoretical framework informed their understanding to social workers, but they attempted to phrase this in non-specialist terms, perhaps to translate it into a 'language' that social workers could easily make sense of (although as can be seen

above, on occasion they slipped into psychoanalytic terminology, perhaps indicating there were sometimes difficulties with this translating). Field notes recorded that after the child psychotherapists spoke about this, the UASC Team Manager opened up about how she perceived social workers to protect themselves, for example by focusing on the performance-led aspects of their tasks, saying this 'acts as a buffer, and workers aren't always connecting emotionally to cases. That's how people cope'. She then responded positively to the child psychotherapists' suggestion of a space to think through these issues, saying she welcomed a monthly reflective space offered by CAMHS. During interview, the child psychotherapists also commented that their discipline-specific identity informed the position they took when speaking to members of the professional network; for example, by highlighting potential projections occurring within the network.

5.4.2.2 Sub-category 2: CAMHS team member identity: 'The CAMHS perspective'.

Analysis suggested that the child psychotherapists also adopted an identity of 'generic mental health clinician', primarily shown through their assertion as a member of the CAMHS team. This identity appeared to be the dominant identity in their interactions, and consultations with social workers. Observations demonstrated that CAMHS team members, including the child psychotherapists, frequently used the phrase 'the CAMHS perspective' or 'CAMHS point of view' in consultations with social workers. One feature of 'the CAMHS perspective' was shared decision-making within the team and valuing the perspectives of all team members, as shown by the following examples from field notes during general office observations and CAMHS team meetings. The team shared work on complex cases when 'it's a lot for one person to hold' (Alice, field notes 09.08.19), as well as sharing informal elements of their practice, such as writing emails across desks together. Field notes during general office observations recorded that CAMHS team members took time to think through aspects of each other's cases in great detail, both during team meetings and informally across desks. A consequence of having this thinking time to process was that team members were intricately aware of each other's cases and could liaise with other professionals in the absence of the main team member working on that case. Asserting their identity as a CAMHS team member was evidenced in other ways. As

can be seen from Appendix 17, which shows the office layout, the office was divided in two sections with hot-desking used throughout. The CAMHS team all chose to sit in one section, on adjacent desks if available. When questioned on the reasoning for this, they said that over time they had gradually gravitated towards that side and each other.

The CAMHS team were all employed on the same NHS salary banding, following the loss of their Team Manager several years previously in a cost-saving exercise. This absence of hierarchy appeared important to the teams' functioning and largely appeared to facilitate the child psychotherapists in their role. Absence of hierarchy and its impact was evidenced in several ways. With the withdrawal of administrative support, during team meetings CAMHS members took it in turns to record minutes as it was the most 'democratic' (Alice, field notes 18.07.19) way. Alice described the team as 'small' and 'tight' (field notes 07.06.19), and it was clear from general office observations that their relationships were built on friendship, respect, and camaraderie, with humour used often. Field notes and interviews with both the child psychotherapists and other members of the CAMHS team suggested that all team members positively identified with their identity as a 'generic' member of a mental health team, rather than being ambivalent towards it. Potentially this may stem from their specific working environment as described above, with an absence of hierarchy, a small team, and relationships built on friendship.

Conversations with the team suggested that they positioned their identity as a CAMHS team member by differentiating themselves from generic CAMH services. For example, they perceived their team as having a different, more flexible way of working compared to generic CAMH services; they described how in CAMHS a clinician only has funding for a limited number of therapy sessions and would then need to seek an extension from their manager, whereas in this team they could work with children and young people for much longer periods. The team thought this more flexible way of working suited the children and young people within their remit; field notes of a conversation with Alice record she said 'there is a point in treatment with looked after children where you feel like you're actually doing treatment – at first it can take a while to engage these children' (field notes 18.07.19). This demonstrates her perception that having flexibility to provide therapy for longer time periods meant they could firstly focus on developing the relationship with the child or young person in the initial stages, viewed as distinct from generic CAMHS.

The shared 'CAMHS team member identity' was also used by all CAMHS team members as a means of processing the feelings surrounding the children they worked with, including feelings unconsciously communicated from the social work team. Observations recorded that the CAMHS team meetings appeared to be a chance to 'metabolise' and 'digest' cases (Alice, field notes 07.06.19), as well as other issues impacting on their practice. During interview, the child psychotherapists commented that the CAMHS team meetings enabled team members to hold the levels of disturbance, uncertainty, despair and anxiety surrounding these children and their circumstances. Alice said she felt 'full up' (field notes 07.06.19) before meetings and anxious if she was unable to attend. She described the meetings as an outlet to discuss their feelings, anxieties, distress and anger, to prevent them from repeating or acting these feelings out in their practice. I observed team members to show their support for each other when one team member was having dilemmas about their role or a particular case. Field notes from a CAMHS team meeting record the following:

Mia says she met with one of the UASCs this morning and she is finding it hard to tell how helpful she is being. Alice has been sitting quietly during this discussion and then steps in to say that she is thinking that Mia's work with this young person is important as 'someone's got eyes on him [i.e. the child]' – just having someone who can see him and hear his story is important. [Counselling psychologist] agrees and reassures Mia that she is doing something, and it is important for this young person. [Psychiatrist] comments that this kind of work takes time and the first few months are often just sitting there with these kids. She says the fact they keep turning up to sessions show something – they appreciate the continuity (Field notes 05.07.19)

Here all CAMHS team members reassure Mia about her role with a young person. Thus, the support of the CAMHS team was useful in helping team members to manage their own crises of confidence, or in responding to dilemmas – or even perceived failures – in case care. For example, following an unexpected placement breakdown, I observed Mia to appear very saddened and questioning of her contribution to this breakdown in relationship between the young person and foster carer. The support of her CAMHS team members appeared crucial in validating and

managing these feelings. I observed all team members to acknowledge each other's feelings on other such occasions, with no discipline taking the lead on providing this 'reassurance' role.

Analysis suggested that the child psychotherapists also identified with the CAMHS team identity as a strategy for managing uncertainty and the anxieties that arose from this, when operating in a setting that created many uncertainties for their role. To briefly describe the uncertain environment, in recent years the local authority had faced cutbacks to services and also introduced a culture of systemic practice, which had impacted on the CAMHS team in several ways. The CAMHS team had faced a change in their working practices, with more emphasis on their individual therapy and less emphasis on training and consultation-based services. The child psychotherapists had specialist knowledge in working with young children (under 5s) and had previously run a consultation service for professionals working with this age group, however this was cut due the changing nature of social care referrals. Furthermore, in interview the social care Service Manager explained that the local authority systemic clinical team were taking on the bulk of consultation and training work: 'I think ultimately we would like them [the LAC CAMHS team] to be doing more, having that emphasis on the direct work...I think with the individuals that's often the realm of the psychotherapists isn't it?' (Interview with social care Team Manager, 14.11.19). This quote demonstrates the perception that child psychotherapy was more suited to the therapeutic aspect of practice as it was individual-facing, whereas systemic practice was outward-facing, and therefore suited to the consultative aspects of practice. This perception was in contrast to the child psychotherapists' perspective about their position in providing consultation to the professional network; Alice said they had 'fought vociferously' (field notes, 05.07.19) to hold on to aspects of their practice, such as the under-5s consultation service. I also observed that the whole CAMHS team experienced problems with 'officially' recording their daily activities and workload. There seemed a mismatch between the work they were monitored on (number of children seen per month) versus the nature of their work, the bulk of which comprised liaison and support to the network, often informal. The CAMHS team perceived this activity monitoring to reflect the wish by commissioners that they focus on the aspects of their role which involved directly working with children and young people.

Despite being co-located with social care, fieldnotes recorded several instances of the CAMHS team not being fully integrated into the setting in practice. The team had no administrative support, and although they had a dedicated room for therapy sessions and team meetings, there were several instances of the room being used by social workers even when it was blocked out for use by the CAMHS team. The child psychotherapists said that they had similar issues in accessing facilities in the local mainstream CAMHS office, where they conducted most of their therapy sessions; they had no permanent desks and only limited access to the computer systems. Alice reflected that she felt their experiences of being the 'fostered' team replicated the experiences of the children and young people they worked with (field notes 21.06.19).

The CAMHS team member identity was used by the child psychotherapists as a means of managing these uncertainties. For example, field notes recorded that at times they experienced frustrations, but these could be explored in CAMHS team meetings, such as identifying their own feelings of blaming or splitting with other services. It appeared that the purpose of this reflection was to help them to not act defensively in their practice. The CAMHS team member identity also gave them a solid foundation with which to take a position within the network. Often this involved using 'the CAMHS perspective' as a means of showing shared team identity. For example field notes from a CAMHS team meeting, in which they discussed tensions with the professional network over who would deliver training to foster carers, recorded that the psychologist said that when they emailed the Heads of Service, 'I felt like it should be a shared team perspective, not just from me' (field notes, 06.09.19). There was a sense that 'the CAMHS perspective' gave the team greater authority with which to argue their position in the network; transcending their individual perspectives.

5.4.2.3 Sub-category 3: Professional network member identity.

The child psychotherapists adopted a third identity in their role in this setting, as a member of the child's care network. This identity formed an integral part of the way they operated in this setting; their role did not just involve working in isolation, as child psychotherapists, or even as members of a CAMHS team, but an important part of their role was being a member of the professional network around the child or

young person. This identity was complex and often used in interaction with the other two identities, as will be described. There was also a tension in holding this identity, because it did not mean they shared a 'unified' identity with other professionals, and indeed they often had to register a difference of perspective to other agencies.

In interview, the child psychotherapists reported that when they were present with all members of a child's care network, they came with their core identity as a psychoanalytic child psychotherapist, however they also adopted an additional identity – as a member of the professional network. They perceived that, when a network functions effectively around the child, all members of the network share this common identity. From the child psychotherapists' perspective, an important function of this shared identity was enabling professionals to hold all aspects of the child together. Alice said,

One idea is that the child's experience is so fragmented, there's not one person, one parent, holding it all. So that means the network has to do that, hold the child, hold their experience. There's something about when the whole network is together you feel you have an identity both as a therapist but you somehow work to think both about the parenting function of all the bits together, but also the fragmented bits of the child, how they split bits of themselves or bits of their experience (Interview with Alice, 08.05.20)

Alice perceived that often these children or young people fragment their experience into different parts of the network, and it is only when the network comes together that they, as professionals, can fit those fragmented pieces together and hold the whole child's experience. She perceived that when a network functions well, it acts as a functioning parental unit around the child, enabling the child to feel held by them. This perspective draws on her psychoanalytic framework, demonstrating that her discipline-specific identity informed her understanding and use of her identity as a member of the child's care network. The child psychotherapists' discipline-specific identity also enabled them to see splits within the network itself; Mia said, 'one of the classic splits and fragmentations in networks is the child is very good at school and difficult at home. It's very easy for people not to grasp what that might be about and to connect that together' (interview 08.05.20). The child psychotherapists felt that by bringing the network together on a shared task, professionals could connect the

different aspects of the child's experience together. Alice commented that the network was often brought together to focus on a task, whether that be something concrete such as planning placement moves, or more subtle tasks such as thinking about a problem a child or young person was experiencing. This joint task facilitated the adoption of the network member identity, giving an opportunity for network professionals to think together as a shared unit.

There appeared to be a duality to the child psychotherapists' approach of working with the professional network. They perceived that they shifted between an 'inside / outside' function, by 'observing what's going on in the network but recognising we are part of it as well' (Alice, interview 08.05.20). When they were 'inside' the network, with their identity as a member of the child's care network dominating, they were fully part of the network as 'stakeholders' (Mia, interview 08.05.20) in thinking about the child's experience. This view was supported by field notes, which recorded several examples of the child psychotherapists positioning themselves as 'in this together' with social care, using phrases indicative of a collaborative approach. Field notes from a professionals' meeting held after an incident in which a child presented at hospital, recorded that when a social worker said, 'that's the local authority's job, people don't like us' (SW2, field notes 14.06.19), Alice responded with, 'not just you, but us' (field notes 14.06.19). This appeared to impact positively on the social worker as at the end of the meeting, she said she appreciated this space to think as she felt she was 'sharing the emotional load'. The child psychotherapists recognised that, when adopting this identity, they could also get enmeshed in dysfunctional network thinking, or replicate aspects of the child's experience. Mia said, 'when you're right in the network, it's not like we're always being so thoughtful about what's going in, cos you're in it. You have to be in as you're part of it' (interview 08.05.20).

In contrast to this, the child psychotherapists reported attempting to pull themselves 'outside' the network, by observing and making interpretations about processes occurring in dysfunctional networks. Alice said,

You also have to be able to come outside of it and think what's going on here, what am I doing, what are we doing? So I think it is again that need to travel a little bit...and taking up your internal part of it but also coming out and thinking about not just the network but your part of it... I mean that's so often the case,

we're holding all the despair [as child psychotherapists], this child's going to really suffer. It's very easy for us to hold that part and hold the child's experience. And sometimes just registering that you're doing that and trying to hold that and bring it back in a way...you can't always do it a lot of the time. It's hard work (Interview with Alice, 08.05.20)

Here Alice uses her discipline-specific identity to pull herself outside the network. As the above examples demonstrate, the child psychotherapists often drew on a framework about organisational defences, splitting and projection in terms of how they conceptualised their inside/outside position. When Alice shifts back into the network member identity, she does so using her psychoanalytic understanding of network dynamics, presenting this to other professionals as a means of focusing and unifying them on the task at hand. This perception of pulling themselves 'outside' the network was also supported by observations, for example field notes recorded instances of the child psychotherapists discussing their own feelings with CAMHS team members (such as becoming identified with aspects of a child's experience), and then thinking together as a team about feeding this awareness back into the network.

This identity was also used by the child psychotherapists to keep in mind the perspective of other agencies. The entire CAMHS team, and social workers in the social care team, perceived co-located teams as important in enabling them to understand the other teams' own pressures, agenda, and position. Mia thought that working directly with social workers resulted in a different way of working to generic CAMH services, in which all the 'little decisions' (interview with Mia, 08.11.19) on cases could be thought through as joined up agencies on a day to day basis. Alice said,

I just think if you're working in a generic team there is a sort of shared language, broad language around mental health... and I think with working so closely with social workers, you have to find ways of talking, sort of translating what you know and what you think into everyday language that people can really get hold of. I think some of that partly because otherwise you'd misunderstand each other, you have to find a way in which the social worker can feel that they can also understand what you're saying but be able to use it and convey it when they need to (Interview with Alice, 08.05.20)

This demonstrates that co-located teams were perceived as important in facilitating their identity as a member of the child's care network. Alice uses a metaphor around 'translation' – suggesting that she perceived the clinicians in the CAMHS team, and the social workers in the social work team, to have different understandings or use different 'languages' and terminology. As part of her professional network member identity, she adopts a language that she felt was appropriate for the social care team; different to the way she would talk to Mia, or to the other clinicians in the CAMHS team.

There was a tension in this identity because CAMHS and social care were separate services, with different agendas, responsibilities, and positions. Holding this identity did not mean that the child psychotherapists shared a 'unified' perspective with social care and other agencies. However, when they held a difference of opinion, the child psychotherapists perceived that they utilised this identity as a strategy for understanding why social care held a perspective that was different from their own. Mia said, 'I try to think myself into the network' (interview 27.03.20). They perceived that this identity therefore enabled them to modify their own view in certain situations, when they understood social care's differing perspective and position. This view was also shared by social workers interviewed, for example one social worker described negotiation between their view and the child psychotherapists' view as a process of 'meet in the middle' (interview with SW21, 28.11.20).

Field notes demonstrated that there were also limits to the child psychotherapists' identity as a member of the child's care network, and perhaps occasions whereby they held ambivalent feelings towards adopting this identity. At times of disagreement with social care, I observed that the child psychotherapists appeared to revert to the CAMHS team member identity. An example is shown by field notes from a meeting between Mia and a social care manager, in which they disagreed over sibling contact. After initially attempting to placate the manager and agree on a shared strategy going forward, Mia eventually reverted to the CAMHS team member identity to get her viewpoint across more strongly, saying, 'ok my clinical judgement is she is putting her child at risk. This is the CAMHS perspective'. This example demonstrates that at times of disagreement with other agencies, the child psychotherapist on occasion did not integrate their three professional identities and instead the CAMHS team member identity dominated. My sense was that they

perceived this to have more authority than their individual perspective. Although at the time, this shift did not impact on the social care manager changing her perspective, following this meeting, Mia discussed her concerns with her CAMHS team members. They agreed that Alice should become involved as well, offering for her to accompany the social care manager to a home visit with the family. Field notes over several observation days recorded that subsequently, the two agencies collaborated positively together.

5.4.3 Category 2: *Shifting between professional identities while engaging in their role*

Category 2 describes the actions and processes the child psychotherapists engage in in their role, which are presented as four sub-categories: *advocating the child's perspective and experience; attending to social workers' feelings and anxieties; investigating, and challenging, thinking and decision-making; and facilitating a sense of agency in social workers.* As detailed under each sub-category, while engaging in these processes, the child psychotherapists draw on and shift between their three professional identities. Figure 3 displays the processes.

Figure 3

A visual representation of the processes the child psychotherapists engage in in their role



5.4.3.1 Sub-category 1: 'A reminder to focus on the child': Advocating the child's emotional and psychological life.

One of the principal roles adopted by the child psychotherapists in this setting was to keep the child's emotional and psychological life at the forefront of network thinking. Often this involved providing an understanding to social workers of what the child may be communicating through their behaviour and helping social workers to develop their own understanding of this. For example, field notes from a consultation between Alice and a social worker recorded that Alice talked about a child with a fear of flying, of aeroplanes falling out of the sky. Alice said she thinks 'what she really meant is that she has a fear of being dropped' (field notes 09.08.19), thus demonstrating her perception that the child's outward communication gave an

indication of her, often unconscious, feelings and internal world. In interview the child psychotherapists described wanting to develop connections between an internal world and an external world, which they thought was fundamental and specific to working as a child psychotherapist in a children in local authority care setting,

The thing with the looked after children generally is that there are so many external intrusions and impingements...that we're always working a bit on the inside and the outside. If we just went to meetings and simply talked about the internal world of the child, it's got to be in some way that relates to decisions that are being made. (Interview with Alice, 08.05.20)

The above quote illustrates Alice's shift between how she sees her discipline-specific identity, and her identity as a member of the professional network, while engaging in this process. While her theoretical framework informed her understanding of a child's experiences, she was acutely aware that she needed to make these translatable into a way that relates to the external world within which the child operates, and to the professionals working in their network.

Keeping in mind the child's experience could be difficult to maintain for social workers, amongst their many other tasks. In interviews, social workers reported valuing the child psychotherapists' presence as a 'reminder' to focus on the child,

I think with social workers you've got so many things to think about that you forget, and you've got an agenda like I say a bit of a tickbox, right ok what's going on, have you done your appointments, attended that appointment, done this, done that, or benefits, whatever it is. And you get caught up in that. And it is a bit of a reminder to think about what's actually going on for them.

(Interview with SW4 05.12.19)

The child psychotherapists' role in keeping the child's emotional and psychological life in mind was evidenced in several ways. Practically, observations showed that they often instigated meetings with key professionals, as a way of pulling the network together, often in response to an incident. The CAMHS team, in comparison to other agencies, often held the child's history for long periods of time, using a distinct

'phase-in-phase-out' approach rather than closing and reopening cases. On questioning Alice about this, she thought this way of working was different to social work as a profession, who often think in the 'here and now' (field notes 07.06.19), with a focus on forward planning. She felt that the CAMHS teams' way of working meant the child's history could be represented in network thinking, situating their current presentation in terms of understanding historical factors. Both child psychotherapists thought their discipline brought something unique to understanding the complex connection between past experiences and a child's current behaviour and responses to relationships. They described their approach of thinking about patterns of behaviour and responses that might emerge, including inter-generational patterns of behaviour; Mia said, 'I think we do hold quite a lot of that because we tend to, partly because we've worked here a long time, we tend to hold cases a long time. And things get easily lost and I find myself saying no this pattern is very familiar' (interview 08.05.20). Mia spoke about the way she often found herself making connections between a child's experiences that are present, and yet resonate so vividly and viscerally with past experiences and emotions.

This view was supported by field notes of professionals' meetings, which recorded that the child psychotherapists spoke passionately and compellingly in their role as advocate of the child's internal world. Observations showed them to use emotive language, for example field notes from a professionals' meeting regarding a sibling group recorded that Alice said, 'this is a child who is feeling desperate and tortured inside...it's a disturbing situation' (field notes 14.06.19). This language appeared to be used as a means of communicating the depths of the child's feelings. Field notes recorded that emotive language often appeared to be used by the child psychotherapists at times when they wanted to demonstrate their perception of the child's experiences and mind strongly to professionals, for example if they thought that professionals were not understanding their perspective. Interviews with social workers supported this, for example one social worker commented, 'I guess if I'd seen that play in the child I might not have interpreted it in such a way, but when she described some of it and how I guess deep-rooted that was; a representation of something inner and something emotional that the child is feeling' (Interview with SW21, 28.11.19). This emotive language also appeared to be used as a means of encouraging social workers to connect with the child's pain, something the child

psychotherapists perceived they were often prevented from doing by protecting themselves against feeling that pain.

Field notes of CAMHS team meetings recorded that the child psychotherapists showed empathic feelings towards the child in their role and were comfortable with discussing these feelings. There was a sense that this ability to be in touch with their own feelings stemmed from both their training and also the support afforded to them by their CAMHS team members; Alice reported that team meetings were an opportunity to 'free associate' (field notes 07.06.19). On several occasions the child psychotherapists' whole demeanour reflected feelings of pain towards the child's situation, for example as field notes from a CAMHS team meeting demonstrate,

The second referral is concerning a young person who has a very traumatic history. Alice looks shocked and saddened when [counselling psychologist] has finished reading the referral. I feel shocked and saddened too. The whole team has gone very quiet and I wonder if it is the weight of the referral information. Eventually Alice breaks the silence by saying, 'how are you supposed to feel? He's lost his family. It's too much.' (Field notes 05.07.19)

This quote illustrates the observation that all team members, and myself as an observer, felt impacted by the depths of the young person's experiences. Alice's role in this instance was to put those feelings into words. This example also illustrates the child psychotherapists' acknowledgement that they did not always know what the child or young person was thinking or feeling. In interview, the child psychotherapists reported that when presented with a new child or young person, they firstly engaged in 'really trying to understand things from the child's perspective...it's not like we know absolutely everything. We have some generic thoughts and understanding about children...but I think when it comes more about an individual child obviously we're doing a lot of work trying to understand them' (Alice, interview 08.05.20). At times my field notes recorded that this 'not knowing' could lead to dilemmas about where to even begin working with a child, for which the child psychotherapists often sought the support of their CAMHS team members for advice on how to proceed. On other occasions they fed this uncertainty into network thinking as a means of encouraging professionals to understand that they did not always need to know the answers on a case, and to tolerate this uncertainty of 'not knowing'.

5.4.3.2 Sub-category 2: 'Sharing the emotional load': Attending to social workers' feelings and anxieties.

Field notes of CAMHS team meetings suggested that, during case discussions, the child psychotherapists perceived there to be high levels of conscious and unconscious anxiety for professionals working in this field; recording that they often framed their understanding in terms of the defences they felt social workers and other professionals used to protect themselves from this anxiety (therefore drawing on their discipline-specific identity to frame their understanding). For example, during the observation period social care were receiving an increasing number of referrals for UASCs, with a subsequent effect of increasing numbers of CAMHS therapy referrals. During a CAMHS team meeting, the team reflected on what could underlie this:

Alice says she's thinking about the social workers and that they don't know where to start working with these young people. Alice thinks it is overwhelming work for the social workers – even one story is horrific and unbearable if you put yourself in that young person's position. Alice thinks the social workers are saying 'it's too much' for them to think about by pushing all these referrals on CAMHS. [Psychiatrist] comments that these young people need help with the most basic things – they're in a new country, they don't understand the language etc – but even things like providing them with an oyster card seem to be difficult for the social workers. Alice says that the social workers are in a more complicated position than the CAMHS team – she thinks their sense of guilt is massive as they are doing age assessments on the young people and having to say 'we can't give you this'. Alice thinks the social care team are employing an organisational defence – it is easier just to cut off emotionally from it. Alice says she is conscious that they don't want the CAMHS team to be the 'goodies – the country that takes them' while the social workers are the 'Home Office'. (Field notes 05.07.19)

The above example demonstrates that Alice perceived social care as potentially wanting to relinquish emotional responsibility for the child by passing referrals on to CAMHS for therapy. Alice perceives the defences to not just be held within

individuals but replicated at an organisational level. Furthermore, it demonstrates the empathy and normality that Alice places on these feelings experienced by social workers, and the recognition that the social care and CAMHS team were in a different position to them, and the potential splitting dynamics this could engender, as well as the wish to avoid such splitting.

Another example of how the child psychotherapists framed things as a defence is drawn from field notes during another CAMHS team meeting, in which they discussed their perception that Mia was being 'excluded' from decision-making meetings:

Mia says 'how do we say to this network that what you're doing is not in the best interests of the child?' There is a brief silence and then Alice raises another question by asking the team 'what is [name of manager] "pushing out" by excluding Mia?' Mia thinks about this and says she thinks she brings complexity, problems, things to think about rather than simple solutions. Alice suggests putting that to them in a non-challenging way, for example 'I'm having this experience that I bring problems...' Alice says they need to break the pattern of Mia keep having to say 'you're leaving me out'. [Counselling psychologist] suggests they present it as a network issue rather than individual issues, and Alice agrees and suggests they say 'as a network we're repeating things'. Alice thinks that maybe network professionals don't want to think about how unbearable this is for the young person. They don't want someone to say let's think about this. [Psychiatrist] agrees and says 'I think we've got to it, that's what it is.' (Field notes 09.08.19)

The above example demonstrates several facets of the child psychotherapists' approach to attending to social workers' feelings and anxieties, which encompasses all the three professional identities. Firstly, framing their understandings in terms of individual and organisational defences; in this case the defence of excluding Mia from meetings because she brought complexity and challenges to the social workers' decision-making, potentially too painful for social workers to think about (discipline-specific identity). Secondly, their suggested approach of vocalising this understanding to the network, attempting to do so in a way that is non-confrontational. Thirdly, to present it as a network issue that includes the child

psychotherapist in the replication of unconscious dynamics (professional network member identity). Field notes, and interviews with the child psychotherapists, suggested that they were aware that they could easily get caught up in replicating network dynamics, including splits between services. Fourthly, to make space to think through with their CAMHS team members an issue that they perceived to impact on the child's emotional wellbeing (CAMHS team member identity). On questioning the child psychotherapists on this aspect of their practice, they perceived that social workers did not have the same 'space' to reflect, as the field notes below demonstrate,

As the meeting is ending, I ask a question about my observation that when an incident or crisis occurs with a child or young person, the CAMHS team take time to reflect on this and what has happened, or think about what could have been done differently. I ask them whether they think the social care team do the same. Alice and Mia think about this and say they don't think social workers get much space for this kind of reflection. And often when an incident happens, for example a placement breaking down, there are many practical things to do, such as find an emergency placement – and these practical things take over. Alice wonders if they focus on the practical tasks to avoid thinking about things in further detail. It is too much for many of them to think about. (Field notes 30.08.19)

This example also links to observations that a common intervention by the child psychotherapists, as a means of attending to social workers' feelings and anxieties, was encouraging social workers to 'stand back' from situations; to take time to pause and reflect, even in a crisis situation. During CAMHS team meetings, field notes recorded several instances of the child psychotherapists offering reflective thinking spaces to social care, either as a general reflective space, or in response to an incident. On some occasions, these spaces were met welcomingly by social care (as seen in the example under *discipline-specific identity* of the UASC Team Manager accepting a reflective space offered by CAMHS). However, in other instances, social workers seemed less receptive to the child psychotherapists' attempts. During a meeting between Mia and a social care manager to discuss differences in perspective over sibling contact, Mia offered a space for the network to think through what could have been done differently to prevent this happening in the future

(therefore asserting their professional network member identity). Field notes recorded that the social care manager appeared to push this suggestion away, stating 'we should have this reflection at a later stage' (field notes 02.08.19). My understanding of the reasoning behind this was that she had many other practical tasks she had to complete on the case, and therefore reflection was less of a priority. Another example is drawn from field notes of a conversation with Alice after an unexpected placement breakdown: 'Alice says when she spoke to [social worker] she commented on how painful the ending of the relationship was. Alice felt that [social worker] didn't want to think about what was really going on here and kept shutting it down, even though usually she thinks he is one of the most thoughtful social workers' (field notes 30.08.19). These examples suggest a pattern of social workers being less receptive to the child psychotherapists' interventions at times of crisis, which I understood as a wish to focus on the many immediate practical tasks at these times and therefore block out uncomfortable feelings. On speaking to the child psychotherapists about this, they perceived that social workers encountered many feelings of guilt and responsibility in their role, 'so when it's a time of crisis someone thinks 'get me out of this, I just want to get rid of this feeling of responsibility'' (Interview with Alice 08.05.20). Observations recorded a sense that the child psychotherapists' attempts to 'slow things down' at times of crisis could feel frustrating for social workers who wished to focus on the more practical tasks. This perhaps suggested that, on such occasions, the child psychotherapists misjudged social cares' priorities, with the need to adapt their interventions at times when reflection was less of a priority.

The child psychotherapists' approach of attending to feelings and anxieties was also evidenced through their validation of social workers' feelings, providing reassurance of their role. Field notes during a consultation record that Alice told the social worker, 'you're carrying a really important function for this child' (field notes 07.06.19). They often mirrored or mimicked social workers' responses during consultations, for example when a social worker said 'it's helpful' (SW19), Mia replied 'it *is* helpful' (field notes 01.08.19) with emphasis. Although both child psychotherapists worked part-time, when in the office my field notes recorded that they were available for informal consultations or discussions with social workers, often going out of their way to offer informal support. During a general office observation, a social worker was walking down the corridor and Alice called out, 'just

to say I'm here if you want to talk to me. It's not an open case so you don't have to update me, there's no obligation to' (field notes 18.07.19). On several occasions the child psychotherapists were called into social care managers' offices for informal discussions. On speaking to Alice about what she did in there, she said, 'not much, just listening really...it's a bit of a funny one but we sometimes have this function – just to listen' (field notes 14.06.19). These examples demonstrate a sense that the accessibility of the child psychotherapists evoked a sense of safety and trustworthiness in some social workers.

Several social workers reported in interviews that they valued consultations with a child psychotherapist,

I think that they're...sort of like in some senses a consultation can feel like a supervision...but it's more sort of a reflective form of supervision stroke advice stroke guidance stroke consultation. As I'm describing this I can hear Mia, the most common thing she'll say if I'm having a consultation then she'll say 'that's right.' And she says 'that's right' a lot...and sometimes she'll say 'that's right *but*'...there's that kind of verification that actually these things are authentic and you know I have or I did notice there were issues too. (Interview with SW9 08.11.19)

There was a sense that consultations were distinct from their more agenda-led supervision with managers and also an opportunity to discuss their relationship with the young person. As seen from the example above, social workers appreciated the validation that their feelings were understandable ('that's right'), but also the challenge that child psychotherapists could offer ('but...').

5.4.3.3 Sub-category 3: 'Rocking the boat': Investigating, and challenging, thinking and decision-making.

The child psychotherapists perceived that their role often entailed investigating social cares' thinking, and the processes that led to decisions being made. Alice described it as,

Often you find it's not what you think it is, it's not that people have done lots of thinking and think this is the best thing, it's because they're under pressure or because they can't bear thinking about this case any longer. So I think there's

something about sometimes trying to investigate and enquire about, not in a kind of you're just wrong way, but a kind of what has led to this? Or what is making you think this would be the best decision? And then trying to help social workers scope out actually what they do think. (Interview with Alice, 27.03.20)

The above quote demonstrates Alice's perceived approach of taking a curious, inquisitive stance to exploring social cares' decision-making, aiming to open up a space to unpick any underlying pressures that contribute to decisions. Field notes recorded that during consultations, the child psychotherapists could sometimes be direct and 'firm' with social care, offering clear advice about their perspective on cases. Field notes from a professionals meeting concerning a sibling group recorded the following:

[Social worker] says she is concerned that the children won't get support soon as their looked after child status may to be dropped. Alice makes it clear that this is a worrying situation and she doesn't think they should be discharged from services soon. Alice says it's their duty as professionals to offer another side in which services aren't dropped. (Field notes 14.06.19)

In the above example, Alice's assertion of the professional network member identity can be seen. Following this meeting, Alice discussed the case at a CAMHS team meeting, and field notes recorded that she 'thought I had made the social worker think and she could hear what I said' (field notes 14.06.19).

The child psychotherapists were also prepared to challenge if they felt it was necessary. Challenging appeared to primarily occur when they wanted to question social workers' beliefs or assumptions about children and young people. An example is demonstrated by field notes during a consultation between Mia and a social worker following a young person's unexpected placement breakdown:

Mia and the social worker talk briefly about the placement breakdown today, the social worker describes the young person as 'resilient'. Mia replies 'I don't agree' and she sounds quite firm in this. She says she thinks it is a defence, the young person is scared of her feelings, so she clams up and says it's all ok. Mia says she has a problem with the word resilience: 'you can call it that in the short term because it enables [young person] to keep going, but it doesn't

let you get in touch with your feelings. The resilience isn't real and won't last long-term'. (Field notes 02.08.19)

Here Mia adopts her discipline-specific identity to reframe the young person's behaviour using a psychoanalytic perspective, and also, I felt that she questioned a perceived defence by the social worker: the defence of denying the young person's feelings, potentially too unbearable to think about. Field notes recorded that the social worker seemed unsure of what to say after this interaction, and that Mia immediately drew back and said 'this can be a conversation for another time', and after the meeting, said to me 'as soon as I heard him mention the word resilience I had to say something, then pulled myself up for being so frank' (field notes 02.08.19). This perhaps suggests that although they felt challenging was necessary, they thought it was important to be careful about the timing of challenges, and that on occasion they were aware that they misjudged this timing.

Challenging was also used when the child psychotherapists disagreed with social cares' decision-making. An example is shown by field notes from a CAMHS team meeting. Alice discussed her frustration that her opinion was not considered at a network meeting she was unable to attend. She had asked the social worker to present on her behalf, however this was not done:

Alice says she is considering emailing the Head of Service and saying that her thoughts weren't considered at the meeting. Mia says she thinks they need to raise a risk in the local authority's plan – the children are all showing signs their emotional needs are not being met. Alice agrees to draft something and show it to Mia. Alice says she will mention in the email that these children are her clinical responsibility. Mia says 'yes we need to up the ante.' (Field notes 28.06.19)

The above example demonstrates several facets of the child psychotherapists' approach to challenging decision-making. Firstly, the use of language, designed to 'up the ante' by demonstrating the strength of their opinions and using their position of clinical responsibility to show that their perspective should be given serious consideration. Secondly, their willingness to escalate challenges to senior management levels when they felt their opinions were not being heard. Thirdly, the adoption of the CAMHS team identity can be seen, as Alice sought support from

CAMHS team members when challenging. Field notes of several consultations recorded that CAMHS team members often used the phrase 'the CAMHS perspective' when challenging, perhaps to show that it transcends their individual perspective and to add more authority.

Investigating, or challenging, decision-making processes was also used when they felt that a decision was not being made democratically, including the views of all network professionals. As discussed in the previous section, this included instances of the child psychotherapists feeling excluded from key decision-making meetings, for children or young people they were providing therapy for. Although field notes recorded that the child psychotherapist initially appeared frustrated, she decided to arrange a meeting with the social worker and manager to discuss her concerns. The field notes recorded after this meeting ended were as follows:

The meeting ends at 4.30pm and Alice and I go upstairs. I ask Alice if she got what she wanted from the meeting, she looks pleased and says yes. She is smiling. I say she seemed to really rally the social workers up and she says yes, thank you. Upstairs the social workers come back to their desks and joke with Alice about her making them feel good, they are 'ready to face the network like the Men in Black and Wonder Woman'. They are all laughing together. (Field notes 09.08.19)

Here the field notes demonstrate the positivity that resulted from this meeting, in which social care agreed with Alice's course of action. There was a sense that as a result of Alice's challenging, the social workers felt empowered to be more decisive in their decision-making.

When engaging in a process of challenging, on occasion the child psychotherapists utilised an approach distinct from their characteristic style of attempting to minimise anxiety amongst the network. Field notes during a case discussion in another CAMHS team meeting, in which Alice felt that social care lacked a sense of agency over their decision-making, record that she said she wanted to 'induce anxiety so as to mobilise the network' (field notes 05.07.19), and another occasion in which she said they 'need to be unsettled otherwise it's turning a blind eye' (field notes 02.08.19). In contrast to their role of *Attending to social workers' feelings and anxieties*, which primarily involved encouraging reflection and

thinking, challenging frequently comprised a more action-focused stance, in which the aim was more to create perceived appropriate anxiety. I observed several instances of the local authority's decision-making changing as a result of the child psychotherapists' investigating and challenging, for example after a series of meetings in which Mia argued vociferously her perspective regarding sibling contact, eventually the local authority changed their plans over this.

From speaking to social workers during interviews, the child psychotherapists' challenging was primarily received positively, with social workers reporting that it helped them to analyse and think about their care plans in more depth. One social worker said that she viewed their challenging as 'raising a question' to think about (interview with SW2 14.11.19), while another said that he found it useful for 'pushing and extending' his thinking (interview with SW11 14.11.19). One social worker commented that often the notion within the professional network is 'don't rock the boat' (interview with SW2 14.11.19); therefore, they welcomed the different perspective and challenge expressed by the child psychotherapists. Despite this, the challenging could also feel disconcerting for social care. In interview one social worker commented,

I do trust them, their expertise, and the fact that they will challenge something, that means that when they heavily challenge something, it feels quite like 'oh gosh we really have to take that into account'. I really struggled with that case because I still disagreed with them (Interview with SW21 28.11.19)

This demonstrates that the social worker perceived the child psychotherapist as an expert, who it was alarming to disagree with; but also, that she did not accept the child psychotherapist's point of view. On questioning the social worker on how the tension in this case was resolved, she commented that following a series of meetings, the final care plan 'is probably the best one that's happened in that it is somewhere in the middle'; therefore suggesting that negotiation was a key factor in managing the different perspectives.

5.4.3.4 Sub-category 4: 'Getting them to formulate their own ideas about things': Facilitating a sense of agency in social workers

Analysis suggested that the child psychotherapists engaged in the process of *facilitating a sense of agency in social workers* as a means of activating social workers to have 'firm thoughts and their own mind' (Alice, field notes 30.08.19) on cases. This sub-category has some overlaps with their role of *investigating, and challenging, thinking and decision-making*; the child psychotherapists perceived that investigating decision-making processes could lead to social workers having a more authoritative sense of their professional identity. There were also some distinct elements as follows.

The process of facilitating a sense of agency in social workers appeared to primarily stem from the child psychotherapists' belief that on occasion social workers lacked 'ownership' (Alice, field notes 09.08.19) of their cases, described as follows. Field notes during CAMHS team meetings recorded several instances of the child psychotherapists stating their opinion that individual social workers were being swayed by the opinions of other professionals in the network on specific cases, or commenting that 'the network goes to sleep' (Alice, field notes 14.06.19) with cases. Field notes recorded that the child psychotherapists often linked these observations to organisational defences they perceived to be displayed by social workers (the defence of avoiding responsibility), thus drawing on their discipline-specific identity.

The child psychotherapists' intervention in these instances often involved advising social workers to be firm and clear in their decision-making on care plans, thereby aiming to develop an authoritative sense of their own professional identity. This is demonstrated by field notes during a meeting between Alice, a social worker and social work manager (a meeting already described under the *investigating, and challenging, thinking and decision-making* sub-category). Alice had called the meeting following concerns that her perspective was not being listened to by the network:

They talk some more about the meeting that Alice feels her perspective was excluded from. [Social care manager] says she doesn't want to have another meeting like that, there were too many professionals involved and too many opinions. Alice says 'I don't think you should – you should own it as the local authority. It's your care plan'. Alice thinks the network needs tightening up, for

less professionals to be involved. I feel as if Alice is speaking with heightened emotions right now, her voice is raised. Alice says 'I think what you're saying is that for all the systemic thinking, several pieces of the system aren't being listened to, because they have a different view to other parts of the system.' Alice says 'you two need to take ownership of this system'. (Field notes 09.08.19)

Here Alice was firm with the social workers about taking responsibility for their care plan, as the agency with corporate parent responsibility for the children. She appears to be shifting between her identity as a professional network member, but also recognising the differences between agencies and therefore aligning herself with the CAMHS team member identity. Alice was very direct with the social work manager during this meeting, at one point stating, 'the bottom line is this is your responsibility' (field notes 09.08.19). The above example also Alice's use of systemic language ('several pieces of the system aren't being listened to') as a means of engaging social care in a framework she thought they would connect with. As a result of this meeting, all parties left feeling buoyed up, with the social workers reporting that they felt 'ready to take on the network' (SW2, field notes 09.08.19), in what Alice hoped would mean they made their opinions more known to other network professionals. In interview, the child psychotherapists commented that they perceived social workers to have a very distinct role from theirs, with a different task and responsibility. They described, 'wanting social workers to feel that they have their own valid authority in their role, their role has a proper and distinct place in relationships with a child' (Mia, interview 08.05.20); therefore wanting to encourage social workers to own their legitimate position in their relationships with children. As this study is a case study, it is difficult to assess the extent to which this 'directness' on behalf of the child psychotherapists to facilitate a sense of agency in social workers is generic to the work of child psychotherapists in the field of children in local authority care (this will be discussed further in the Discussion section). My observations of the two child psychotherapists within this specific service were certainly that in terms of their approach, style of working, and personalities, they were both prepared to challenge social care in encouraging them to take 'ownership' of cases.

The child psychotherapists' role of emboldening social workers to have a sense of agency was demonstrated in other ways. During consultations with social

workers, I observed many instances of the child psychotherapists asserting their professional network member identity by inviting the social workers' perspective, for example field notes during a consultation regarding a baby placed with adopters recorded that Alice said 'I was thinking about this...I don't know what you think?' (field notes 07.06.19), perhaps to form an alliance with the social worker. She then suggested the social worker conduct her own observations of the adopter with the baby and think about what both parties may be feeling, as well as the feelings aroused in herself as the observer. My understanding was that Alice aimed to increase professional confidence by encouraging the social worker to be curious about other people's states of mind, as well as being aware of her own feelings.

During the observation period there were several occasions in which the child psychotherapists offered reflective spaces to social care, for example following an incident in which a young person's placement broke down suddenly. Field notes of the child psychotherapists' discussion with each other recorded the following:

Alice suggests they do something simple with the social care team to think about 'endings' (of relationships), using the incident yesterday as an example of this. Alice says the social care team have so little time to reflect. Mia says 'yes we want to empower them...and to get their perspectives and views on endings'. (Field notes 30.08.19)

This example demonstrates that one function of offering reflective spaces was to invite social workers to form their own perspective, to encourage them to connect with thinking, and promote their ability to articulate their own views.

In interview, the child psychotherapists reported that another process they engaged in was exploring with social workers who they may have become identified with on a particular case,

I think that sometimes can be very helpful because I think it frees them up a bit to think for themselves. I think that can lead you to be pulled in one direction or another, but it also of course has a function of freeing up the network a bit because if people are a little bit more aware of where they're pulled, and that includes us too, you get so identified with the children...but then you are freer to think (Interview with Alice, 27.03.20)

This process drew on Alice's discipline-specific identity. By vocalising to social workers an understanding of unconscious states that are being communicated to them, and an awareness of where they may be being 'pulled' on cases, she aimed to 'free up' their thinking capacities, ultimately leading to an increased sense of authority. The quote also demonstrates that Alice recognises that she as a member of the professional network can also be 'pulled' in certain directions or become identified with a particular child, which could impact on network functioning. Observations of CAMHS team meetings suggest that these served an important function of allowing team members to recognise these unconscious states.

Observations of the child psychotherapists' practice also suggested that they aimed to increase professional confidence by encouraging social workers to tolerate the uncertainties inherent in this work and manage 'safe' risk. One social worker reported in interview that this approach was empowering for her in comparison to other agencies who were more adverse to tolerating risk,

I think working in uncertainty is something that we do anyway...I think there are so many professionals from different agencies that don't allow you to live in uncertainty and don't want you to hold risk, they want you to get rid of it. Whereas I think having that reassurance [from speaking with the child psychotherapists] that it's ok, we don't know what will happen, you can try this but it might not work...it kind of makes you go ok that's alright. And I think it relieves some of that pressure...I think even within management, when you're working with uncertainty and you've got managers who maybe want more of a clearer definition of what's happening and a clearer plan of what's happening...so then we can say 'well you know Alice thinks that too' (laughs). Because I think they are seen as people quite rightly who have that clinical expert opinion. (Interview with SW2, 14.11.19)

This demonstrates the social workers' perception that the child psychotherapists were 'experts' whose opinion was used to add authority to their decision-making, and that it provided reassurance for her about managing, and perhaps sharing, risk. Interviews with social workers also revealed that several were aware of the child psychotherapists' attempts to facilitate a sense of agency in them. One social worker commented that 'pushing onto the therapist makes the young person feel like you

can't contain them' (interview with SW11, 14.11.19), thereby recognising the need for them to take the child psychotherapists' advice and apply it to their own practice, rather than deferring to the clinician for therapy. The same social worker also said, 'after a consultation hopefully we're working with them [the child] from maybe an added or a new perspective' (interview with SW11, 14.11.19). Here a consultation was perceived as a means of upskilling social workers to form their own views, with the incorporation of the perspective they gained from the clinician.

5.4.4 Category 3: Having professional confidence in the child psychotherapist identity and role

As can be seen from Figure 3, the child psychotherapists' own professional confidence in their role and identity permeated all the processes they engaged in (and their professional identities), and was therefore developed into its own category. Analysis suggested there was a disparity between social workers' perceptions of the child psychotherapists (as 'experts') versus how the child psychotherapists perceived themselves and attempted to portray themselves to social workers (as having 'professional confidence' in their role and identity, but not being 'experts').

Interviews with, and observations of, social workers, revealed that they held the CAMHS teams' views in high regard. Social workers expressed a high level of respect, and perhaps also something approaching admiration, for the CAMHS' teams views, with several suggesting they privileged their opinions over other sources of knowledge. In interviews several social workers struggled to distinguish between disciplines within CAMHS, therefore this role as 'mental health expert' applied to the whole service and was not specific to child psychotherapists.

There was a sense that CAMHS' opinion was 'weighted' more than a social worker in certain environments, for example in court. In interview, one social worker described this as a 'professional pecking order', commenting that adding a CAMHS perspective to a court report made him feel 'powerful' (interview with SW11 14.11.19), and thus suggesting that the expert opinion gave social workers more authority in their statements and decision-making. Another social worker explained the sense of relief that CAMHS' support could give them, describing the child psychotherapists' opinion in writing as 'something for the child's file...you've got the

mental health professional saying there's no significant risk, there's a bit less pressure on you' (interview with SW8 28.11.19). This example suggests the social workers' wish to share risk with CAMHS, as well as potentially the risk-management of having the child psychotherapists' perspective recorded on the child's file.

During interviews, several social workers gave the impression of the CAMHS team as helping them with situations they felt unequipped to deal with, particularly children with significant levels of trauma. One social worker admitted that when she booked a consultation she hoped the clinician would 'jump in and say let's go visit them together...there's a bit of kind of anxiety around mental health, cos I'm not therapeutically trained' (interview with SW8 28.11.19). Another social worker thought these feelings stemmed from social workers' level of experience; those with professional confidence may approach consultation with a clear sense of their own views and the role that they want the clinician to play, 'I just have to remember that whilst they are so expert they come from a...psychotherapy point of view and so they're thinking very much about a child's psychological needs. Whereas in social work you've got all the other factors to balance and you do what you can do, in the best interests' (interview with SW21 28.11.19). This quote illustrates the perception that social care and CAMHS had different responsibilities, and as the corporate parent and agency with key responsibility for the child, social workers had many factors to balance and statutory duties to fulfil. Therefore, although they may seek an expert opinion from a mental health professional, it only formed one part of their decision-making process.

There was a sense this view of the CAMHS team as 'experts' in relation to the child's psychological needs felt reassuring for social workers. They spoke about seeking validation and were pleased when this was offered. In interview one social worker said 'Alice will be like 'yep that's a really good way of thinking about it. And I'm like oh wow. I am actually thinking about this in a proper way'' (interview with SW2 14.11.19). In contrast, viewing the CAMHS team as 'experts' could also engender fearful feelings amongst social workers, particularly when they disagreed with their opinion. In interview one social worker said that it was 'scary' to disagree with an expert: 'I really struggled with that case because I still disagreed with them. And then I found it very hard, it was more difficult to try to justify my disagreement, or to keep justifying it, when they were bringing so much evidence from their point of view' (interview with SW21 28.11.19). There was a sense this fear stemmed from

feelings of inadequacy about their professional status compared to the CAMHS clinicians.

Observations of the child psychotherapists in meetings and consultations with social workers suggested they did not intend to come across as experts. In fact, when I questioned Mia, she thought this approach would be counter-productive, 'if you say this is the expert position you're not going to get anywhere, in a way. What you're trying to do is argue the case really, I made it on this, this, this decision' (interview 08.11.19). Field notes of consultations with social workers recorded that both child psychotherapists frequently sought the opinion of social workers, perhaps to form a sense of alliance, in that they were both members of the professional network thinking together on a problem.

My understanding of the child psychotherapists' approach was that, instead of presenting an 'expert' view, they had professional confidence in their opinions and decision-making. This is not to suggest they did not experience dilemmas in their role and interventions, but that they had professional confidence stemming from their theoretical framework (discipline-specific identity), that gave them a basis for understanding behaviour; both the child or young person's, and the professionals working with them. They sometimes engaged in a discipline-specific pedagogic role, teaching social workers a set of theoretical ideas (albeit in non-psychoanalytic terms) to help inform their thinking and practice. For example, Alice said she attempted to restore a sense of agency in social workers by providing an understanding of the concept of projective identification; that their own difficult feelings on a case may stem from the child projecting feelings into them.

The child psychotherapists' professional confidence also appeared to be aided by the support of the CAMHS team and the adoption of the CAMHS team member identity, as any dilemmas could be discussed in a supportive team environment, and put forward as a shared position. Finally, the child psychotherapists perceived that their professional confidence was supported by the external supervision they received from the local generic CAMHS service; Alice commented that although they were a 'satellite' service they 'had a backbone that's elsewhere' (interview 08.05.20), giving them a sense of alliance with another service and management structure.

Although they did not aim to present as 'experts', observations showed the child psychotherapists to assert their authority as clinicians with professional

confidence during consultations with social workers. Field notes of a consultation in which the social worker sought the child psychotherapists' opinion regarding a court statement recorded that Alice said, 'you can put in the court statement that you've had a consultation with CAMHS and they are concerned about the psychological pressure that mum is putting on the children' (field notes 13.09.19); therefore indicating that the 'CAMHS perspective' was used to add authority. Field notes of other consultations recorded instances of the child psychotherapists warning social workers about children and young people seeing therapists from external organisations, as they were concerned about the levels of training that other therapists may have undergone.

The child psychotherapists perceived that professional confidence in their identity also enabled them to do applied work in this setting, which they thought was distinct from child psychotherapy in a generic CAMHS team, largely based in the clinic. During the observation period, the child psychotherapists attended many different settings for both meetings and therapy sessions, such as schools or foster carers' homes. They perceived that holding a 'fundamental internal setting' in their minds, of both therapy room, and core concepts learnt during their training, enabled them to work in different contexts and speak to different professionals and family members in a relatable way,

We're not purists in the sense that we're working with a toy box with every child and we're having the setting with every child, but I think we have that setting in our head. A fundamental internal setting. Which is what allows us to move around and to speak in different ways and different registers...you have to have your identity as a child psychotherapist really integrated in a core way inside of you to be able to do good applied work. And that it's a real mistake to think you know you need the most speedily qualified people to go out to do work in schools, 'ok it's not real child psychotherapy, it's not really psychoanalytic'. That's rubbish. It's very, very demanding to do applied work properly and really depends on an integrated professional identity (Interview with Alice, 27.03.20)

In a conversation with Alice, she raised the question of whether their training, knowledge, and capacity to work with the feelings of these children and young

people, stirred up feelings of envy and rivalry in social workers, who perhaps lacked a theoretical framework with which to interpret behaviour. In interview, I asked one social worker about this and she said that it was 'a relief' to know that her young person could build a relationship with the child psychotherapist that was different to the relationship she built as a social worker, 'I don't feel any, have any negative feelings towards Alice. I think it's great that she's [the young person] able to talk, so she talks to me about things but she's maybe able to talk to Alice about, a lot of other things that I probably wouldn't be able to deal with. It's a relief' (interview with SW4 05.12.19). Her perception was that children and young people looked after can harbour 'complex feelings' towards social workers, therefore she relished having a separate service with which young people could build a different relationship with a therapist.

Having professional confidence enabled the child psychotherapists to fulfil their role in this setting and contributed to them integrating the three professional identities. However, despite this professional confidence, there were instances of what I understood to be limitations to the authority of 'clinical responsibility'. For example, after observing a discussion between Mia and a social care manager, in which they disagreed over sibling contact in a case, I asked Mia what she can do in these situations. She said, 'all I can do is put my position forward...she's [social care manager] already made her decision' (field notes 25.07.19). Field notes recorded that she sounded quite resigned when saying this. This therefore suggested that, although the child psychotherapist could argue their perspective vociferously to social care, ultimately there were instances where corporate parent responsibility outweighed clinical responsibility in this setting. In these instances, the child psychotherapists reported that they would 'register a difference' (Alice, interview 08.05.20) of perspective, and in some cases even close the case to CAMHS if they were unable to see a viable role for them. However, they hoped that eventually they may be able to 'reconcile, that the views might come together a bit more' (Alice, interview 08.05.20), suggesting they would often leave an opening for cases to re-open to CAMHS in future.

5.5 Discussion

This section firstly reflects on the study's findings in relation to the research question. Then, the research findings are situated within the existing literature and theoretical constructs. This is in line with grounded theory methodology, as a means of extending the explanatory power of the theory and developing the researchers' theoretical sensitivity. Finally, I discuss implications of the study's findings for knowledge and practice, and directions for future research.

5.5.1 *Relating the study's findings to the research question*

This study aimed to explore how psychoanalytic child psychotherapists function in a multi-disciplinary CAMHS team, in a children's social care setting. The findings were presented as a grounded theory of *Integrating Professional Identities*. The main finding is that the child psychotherapists balanced three elements of their professional identity in their role in this setting. Their role involved engaging in a variety of processes, which ultimately aimed to place the child's emotional and psychological life, as they understood it, at the centre of social cares' planning and practice. The child psychotherapists shifted between identities while engaging in these processes. The analysis demonstrated the intended consequences of the child psychotherapists' actions, while simultaneously specifying how the setting they operated within at times limited them in achieving what they aimed to do.

In terms of their three professional identities, the *discipline-specific* identity forms their core identity and was most apparent in their interactions with the other child psychotherapist, and, from their perspective, their therapy sessions with children and young people. This identity was also asserted during their interactions with social workers; often drawing on theoretical frameworks around splitting, projection, and organisational defences, as a means of understanding behaviour and communicating this understanding to professionals.

The *CAMHS team member* identity was dominant in their interactions with social workers, as they utilised 'the CAMHS perspective' to demonstrate a joint team viewpoint based on psychological understanding of the child, as well as a strategy for minimising anxiety induced by the uncertainties in this setting. This identity also

served a function of digesting feelings surrounding these children, including those communicated by the professionals in their network.

The *professional network member* identity was used in interaction with the other two identities; by bringing the network together as a functioning entity, the child psychotherapists perceived that the whole child's experience could be held by professionals. The analysis detailed instances of the child psychotherapists shifting between identities in their interactions with social workers, therefore indicating that they are not mutually exclusive, and instead there was movement back and forth between them. The theory argues that to be effective in their role in this setting, the child psychotherapists need to have integrated, or found a balance between, the three elements of their professional identity. Although this theory has explicated the conditions under which certain identities predominate, the child psychotherapists needed to draw on and utilise all three identities to be successful in their role, as all served a purpose. Largely the child psychotherapists appeared to be successful at integrating their identities, shifting between all three while engaging in their role. Despite this, they did not always achieve their intended aims; the analysis detailed some instances of tension between the two agencies operating in this setting, and the somewhat limited authority the CAMHS team had compared to corporate parent responsibility. Furthermore, at times of conflict with other agencies including social care, the child psychotherapists appeared to have some ambivalence towards adopting the *professional network member* identity. They instead reverted to the *CAMHS team member* identity to express their differing viewpoint, with the 'CAMHS perspective' adding more authority than their individual perspective.

In terms of the four processes identified through the analysis, the first process the child psychotherapists engaged in was *advocating the child's psychological and emotional life*; the ultimate aim was to keep the child's emotional life at the forefront of network thinking, and enable connections between the internal and external world. The process of *attending to social workers' feelings and anxieties* primarily carried a thinking or reflective function; a key aspect of how the child psychotherapists saw their role was to recognise where they felt anxiety was occurring within the system, and how it was being managed (often defensively), and then to challenge this or invite these anxieties to be named and thought about. On many occasions they were successful in achieving this, however at times of crisis, social workers appeared to be less receptive to the child psychotherapists' interventions.

The child psychotherapists engaged in a process of *investigating, and challenging, thinking and decision-making* to explore the processes that led to decisions being made, including unpicking external pressures. Linked to this process, they also aimed to *facilitate a sense of agency in social workers* as a means of encouraging social workers to take ownership of their cases as the organisation with corporate parent responsibility. Although these two processes involved a thinking / reflective function, they were primarily action-focused, as a means of altering planning or decision-making.

From engaging in these four processes, several hypotheses can be made about the intended consequences of the child psychotherapists' actions, namely:

- The child's emotional and psychological life should be kept at the forefront of network thinking and planning, including connecting the child's internal world and external world;
- The complex connection between past experiences and a child's current behaviour and responses to relationships is considered in network planning, including patterns of behaviour;
- Anxiety in the system is recognised, as well as how it is being managed;
- Social workers' beliefs and assumptions, or perceived defences against anxiety, are challenged or named and thought about. Social workers become aware of ways that they may protect themselves against painful feelings generated by the nature of the work, and how – unless managed – this can create risks to both the individual worker and the task of the organisation;
- Social workers can 'stand back' from situations, even in times of crisis. The intended purpose of this is to promote thinking and reflection, so that decisions and actions are not made defensively;
- Social workers can connect with the child's, and their own, feelings (rather than avoiding);
- Social workers have more professional confidence, a sense of agency in their decision-making, and can articulate their views to the network;
- Social workers can apply the principles listed above to cases which the child psychotherapists are not directly involved in.

There was a disparity between social workers' perceptions of the child psychotherapists, as mental health experts, versus how the child psychotherapists

attempted to portray themselves, as *having professional confidence in the child psychotherapist role and identity*. This professional confidence enabled the child psychotherapists to persist in their role to this setting, despite the uncertain environment within which they operated.

Finally, the analysis highlights perceptions about the distinctiveness of providing psychoanalytic child psychotherapy within a children's social care setting. The child psychotherapists often distinguished their specialist LAC CAMH service from generic CAMHS, for example the flexibility afforded to them to work with children for longer time periods, which they thought suited these children's needs. They also perceived they adopted a role of making connections between the child's internal world and their external world (including the professional network around the child), which was distinct from work with other groups of children. Finally, they perceived that holding a 'fundamental internal setting' of the therapy room in their minds, allowed them to work in applied settings such as schools and social care offices.

5.5.2 *Situating the study's findings within existing theoretical constructs*

The place of the literature review within grounded theory is somewhat disputed among its proponents; grounded theory's founders (Glaser & Strauss, 1967) advocate not undertaking a literature review until analysis is completed, however other authors have contested this (Charmaz, 2014). For the purposes of this study, an initial literature review was undertaken to contextualise and focus the research question. A second literature review was then conducted following data analysis, to link the emerging theory to existing theoretical constructs and therefore extend its explanatory power (Charmaz, 2006). As grounded theory is an inductive methodology, the most appropriate theories relating to the research findings may be derived from diverse fields of study (Locke, 2001). The theories that are most relevant to this study's findings are theories of professional identity, which were applied as a theoretical code to integrate the categories into a theoretical framework.

5.5.2.1 Theories of professional identity.

Professional identity is defined as an individual's sense of self within the context of their working environment (Goltz & Smith, 2014). Professional identity is formed from a combination of various factors including knowledge, ethical standards, culture, morals and values (Shahidi et al., 2014). Crigger and Godfrey (2014) argue that professional identity is formed of both social and psychological components: the social element is the *doing*, while the psychological element is expressed through the *being*. Professional identity shapes an individuals' roles and responsibilities within an organisation, as well as their behaviour in the workplace (Bulei & Dinu, 2013). Theories of professional identity are rooted in sociology, with links to symbolic interactionism (Blumer, 1969) and Erikson's (1959) psychosocial theory of development. The literature related to constructing, or forming, a professional identity will be overviewed in this section, as this is most relevant to this study's findings.

Brown (2015) offers a review of professional identity theories, positing that they are linked by addressing common discourses, namely: the extent to which identities are structurally bound or determined by individual agency; whether they are static or fluid; and whether they are unified or fragmented. In terms of the structure versus agency dichotomy, historically there is debate between theories as to whether professional identity is ascribed by organisational structures, or whether individual agency is instrumental in shaping it. Sociological theories of professional identity in the 1950s and 60s centred on 'structural functionalism', namely the uniform roles that individuals and organisations play in contributing to a functioning society (Martimianakis et al., 2009). This perspective asserts that identification with social structures is instrumental in shaping actions, and individuals therefore act in accordance with, and are regulated by, the expected standards of the profession (Martimianikus et al., 2009). Structural functionalism neglects the role of individual behaviours and choice, in the development of a professional identity (Costello, 2005), while others have argued this perspective views professional identity as static, omitting the role of context in shaping identity (Martimianikus et al., 2009). In contrast, a symbolic interactionist perspective of professional identity posits that individuals take an active stance in interpreting and constructing meanings, and in the process of identity formation, recognising the existence of multiple identities (Zhang, 2013). Furthermore, individual sense of agency in constructing a professional identity is central to theories on 'identity work' (Alvesson & Wilmott,

2002; Snow & Anderson, 1987; Sveningsson & Alvesson, 2003; Watson, 2008). An example is Ibarra's (1999) study of bank managers transitioning through a career change. Ibarra contends that the 'professional self' is a negotiated process in which individuals attempt to reconcile their identity with their work environment. She utilises the concept of 'possible selves' (Markus & Nurius, 1986) by demonstrating how the managers in her study trialled 'provisional selves' that functioned as possible versions of their developing professional identity. She argued that identity formation was an iterative process, in which individuals worked to transfer existing values to their new environments.

Most researchers conclude that professional identity formation occurs somewhere in the middle of this structure versus agency dualism; professionals may accept the identity offered to them by an organisation, but also use their own agency to shape them (Brown, 2015). This perspective resonates with the findings of this study, in that the child psychotherapists' affiliation with their professional theoretical framework, and the theoretical knowledge gained through their discipline-specific identity, served as a core basis for their understanding and behaviour within their working context, giving them professional confidence in their identity and role. However, they used their sense of agency to adapt to their working environment, by shifting between other, contextual-specific identities, defined and redefined as a result of their interactions with others in the workplace. This shift between identities was linked to their shifting roles or tasks, for example, the professional network member identity was adopted when they wanted to bring the network together to assimilate the child's experience.

Brown (2015) reports that debates continue amongst researchers as to whether professional identity is a stable or fluid concept. He concludes that increasingly there is recognition that individuals exhibit a relatively stable and continuing self-concept, that is subject to change or modification within different contexts. This perspective is consistent with the findings of this research study, in that the child psychotherapists exhibited a stable core professional identity as a psychoanalytic child and adolescent psychotherapist, however they also drew on two other identities (CAMHS team member and professional network member) as the need arose, thus exhibiting several 'possible selves' (Markus & Nurius, 1987). There was fluidity in moving between these three identities, and a sense that the child psychotherapists were in an ongoing process of negotiating these identities.

Arguably, their identity as a member of the child's professional network, which they used when attempting to draw networks together to understand the whole child's experience, was at times temporary and limited; at times of disagreement with social care, they often shifted to their CAMHS team member identity instead. The main purpose of this was to provide their understanding of the child's psychological and emotional life, with the CAMHS team member identity adding more authority than their individual identity.

In discussing the dualism of coherence versus fragmentation of identity, Brown (2015) contends that there is again debate amongst researchers. One perspective is that identity work is pursued with the aim of establishing coherent identities (though not necessarily unitary), in which individuals are aware of connections between their multiple identities. An alternative perspective is that identities are ambiguous, fragile, and sometimes contradictory, even in the same social situation. Within this context, the findings of this study suggest that the child psychotherapists were always striving to achieve coherent, integrated identities. However, there was potentially a degree of fragmentation and tensional nature in their identities, particularly the complex professional network member identity. At times of disagreement with social care, they reverted to the CAMHS team member identity to show a difference of opinion, therefore suggesting a potential division between the identities. In these instances, the CAMHS team meetings appeared an important mechanism for reconciling the fractured identities, providing an opportunity for the child psychotherapists to digest and reflect on their weekly experiences.

The literature relating to collective versus individual professional identity (e.g. Adams & Marshall, 1996) is also pertinent to this study's findings. From a symbolic interactionist perspective, Mead (1934) contended that identity is constructed in an individuals' interactions with the social group they belong to, through shared values and beliefs. Through engaging and communicating in the social setting and with others, individuals learn about their roles and regulate their own behaviour to fit in with those around them. Wenger's (1998) 'communities of practice' theory contends that identity and knowledge is negotiated through the way individuals participate in the communities they are members of, mutually defining themselves in relation to the 'familiar' and 'unfamiliar' based on a sense of belonging to a group. There is also an interaction between an individual's own identity and the communities they participate in, such that a person's own identity is not only influenced by the community, but the

community can be shaped by a person's identity. This notion resonates with the work of other identity proponents, such as Adams and Marshall's (1996) assertion that identity formation is reliant on both a sense of distinctiveness and a sense of belonging. The communities of practice framework has been criticised for its emphasis on commonality (Eraut, 1998); there is a danger that within their communities, individuals become reticent to challenging beliefs and practice. Situating the study's findings within this context, the child psychotherapists in this study appeared to seek a sense of belonging to other groups through each of their three identities (namely, with the other child psychotherapist; with their CAMHS team members; and with other members of the child's professional network). This resonates with the communities of practice theory, as the child psychotherapists sought to define themselves based on their community membership. This sense of belonging could be used to bring the 'group' (for example the professional network around the child) together to focus on a shared, unifying task.

However, in contrast to communities of practice theory, the child psychotherapists in this study drew on their uniqueness as a psychoanalytic child psychotherapist to vocalise differences of perspective to other professionals in the network around the child. This is more in line with Engestrom's (1999) 'activity theory', which has a particular focus on multi-agency and multi-professional working. Engestrom (1999) argues that an essential component missing from the 'communities of practice' model is the inevitable 'contradictions' amongst community groups. He posits that these contradictions are an important driver of change as tasks are redefined and distributed within organisations (Crigger & Godfrey, 2014). For progress to be made in creating new ways of practising, these contradictions must be vocalised and openly discussed amongst team members. Through vocalising differences, identifying alternatives, and modelling solutions; changes to practice and knowledge can be made. In this study, the child psychotherapists' challenging of social workers' thinking and decision-making was a driver of change to practice and knowledge, sometimes leading to social workers having an increased sense of agency in their own professional status and role.

5.5.2.2 Relating the study's findings to other literature.

Professional identity theories relate to the core category of this study (*Integrating Professional Identities*). There are additional theories and literature that relate to other aspects of the research findings, which will now be discussed.

As discussed in the Findings section, the child psychotherapists often framed their understandings in terms of organisational defences against anxiety, splitting, and projection, among others. The psychoanalytic literature surrounding defences against anxiety within organisations has already been reviewed in Chapter 4. Bion's (1961) theory of groups is also relevant to this study's findings. Bion's theory has already been described in Chapter 2, including the 'basic assumptions' that groups may adopt that interfere with them functioning effectively on their task. This study's findings echo aspects of Bion's theory: the perception that social workers were of unequal professional status to the CAMHS team, depending on the clinicians to manage their high levels of anxiety; and the defences the child psychotherapists perceived to be displayed by network professional groups, including avoidance, splitting, and reticence to take on board their interpretations. Seen in this context, arguably one of the roles of the child psychotherapists in this study was to identify and interpret those aspects of the 'group' (i.e. the professional network around the child) that were interfering with them focusing on their primary task; through *attending to social workers' anxieties and investigating, and challenging thinking and decision-making*, they attempted to *facilitate a sense of agency in social workers* and promote the group functioning more effectively. Psychoanalytic approaches to understanding groups can also be applied to the CAMHS team itself. Generally, observations recorded that the CAMHS team operated as what could be likened to a 'well-functioning group' (Canham, 2002, p. 113); tolerating individual differences and tensions, being reflective, and having a positive, benign atmosphere. At times, field notes recorded the frustrations that the child psychotherapists encountered towards other agencies as a result of their working environment, for example when Alice described them as 'the fostered team', working in a setting they were not fully integrated to, and being unable to provide some services. While this could potentially lead to the adoption of basic assumptions using Bion's theory (particularly the fight-flight mode in which the group acts with hostility towards a perceived external threat), field notes recorded that having space to reflect on these feelings in CAMHS team

meetings largely seemed to prevent the child psychotherapists from playing out these aspects in their practice.

This study's findings also contribute to the literature on multi-disciplinary working in CAMH services, and multi-agency working within children's services. Within the context of the 'creeping genericism' of CAMH services, this study demonstrates the distinctive voice and role of psychoanalytic child psychotherapy in a specialist LAC CAMH team. The findings suggest they were particularly distinctive in relation to aiming to keep the child's emotional and psychological life at the forefront of network thinking, by connecting the child's internal and external world. Furthermore, observations showed that they recognised where anxiety was occurring in the system and how it is being managed, and then vocalised this understanding to other clinicians in the CAMHS team and more widely to the professional network. This is congruent with previous psychoanalytic literature on the individual contribution that psychoanalytic child psychotherapists can offer to multi-disciplinary working (Granville & Langton, 2002; Youell, 2010).

Previous literature has identified 'role blurring' or 'role confusion' as a possible consequence of increased genericism within multi-disciplinary and multi-agency services (Atkinson et al., 2007); this study found that in contrast, the child psychotherapists had a strong sense of their discipline-specific professional identity. At times the child psychotherapists chose to actively identify with their identity as a CAMHS team member, as a positive means of promoting a shared team identity. This is perhaps in contrast to literature arguing that 'role blurring' is initially perceived negatively by workers before they adapt to a new professional identity (Frost et al., 2005). It may be that the lack of ambivalence towards adopting an identity of 'generic mental health clinician' noted in this study stems in part from the specific setting studied; namely a small CAMHS team, with no hierarchy, and relationships built on friendship and respect for each other's disciplines. It is conceivable that such positive adoption of the 'CAMHS team member identity' may not be demonstrated by child psychotherapists working in other settings and teams. This will be discussed further in section 5.5.3.

This study's findings also contribute to literature on multi-agency working in children's services, particularly regarding children in local authority care, for whom strong multi-agency working is a priority. The setting is an example of centre-based service delivery, where the two services (CAMHS and social care) were based

together but functioned separately. Furthermore, it is an example of a specialist service for children in local authority care, identified as potentially beneficial for addressing these children and young people's particular needs (Callaghan et al., 2004; Golding, 2000; McAuley & Young, 2006; Ward et al., 2002). Barriers to effective multi-agency working identified in this study resonate with those identified by previous research, including tensions around different priorities and agendas, and differences of opinion surrounding proposed interventions (Anning et al, 2006; Easen et al., 2000; Salmon, 2004; Sloper, 2004; Worrall-Davies & Cottrell, 2009). This study also found that, specific to this setting, there was a tension around the limited authority of 'the CAMHS perspective'; at times of disagreement, while the CAMHS team could argue their position, ultimately it was social care who held the decision-making responsibility. These tensions could be managed as a process of negotiation between the two agencies. If the CAMHS team did eventually have to withdraw due to difference of opinion, they left space for cases to re-open to them in future, should the agencies reconcile their perspectives.

In terms of facilitators to effective working relationships, co-located services were perceived as important by both agencies, as has been noted by previous literature (Atkinson et al., 2007). By working closely together on the day to day decisions, both services perceived that they had a good understanding of the others' perspective and priorities, enabling trust and mutual respect to be built (Atkinson et al., 2007; Davies & Street, 2000). Despite the importance of co-located services, the analysis identified several examples of the CAMHS team not being fully integrated into the setting, which could at times lead to frustrations for the team. In these instances, the adoption of the *CAMHS team member* identity enabled the child psychotherapists to manage these uncertainties for their role. Furthermore, the child psychotherapists in this study were often using a process of 'translation' – translating their understandings in ways that they perceived as accessible to social workers and other professionals – perhaps to facilitate greater communication between agencies, who may have different 'languages' and cultures. Finally, this study identified the perception amongst social workers that they perhaps had an unequal professional status compared to clinicians in the CAMHS team, which has been noted by previous literature (Abbott et al., 2005). The child psychotherapists perceived they had a part to play in enabling social workers to recognise their distinctive role in their

relationships with children; and field notes supported this perception around empowering social workers to be aware of this.

5.5.3 Generalisability of findings outside the setting under study

Due to the specificity of the setting under study, case study research suffers from problems with generalisability to wider settings. Yin's (2009) concept of analytic generalisability was therefore used to consider the likely transferability of findings beyond the scope of this study. Yin describes this as a two-stage process; in the first stage, the researcher relates the conceptual analysis to existing theoretical constructs and literature (as described in earlier sections of this Discussion). In the second stage, the theory is applied to other settings comprising similar participants or events.

To ascertain whether the study's findings resonated with the practice of psychoanalytic child psychotherapists outside the specific setting under study, an online webinar with 50 UK child psychotherapists was conducted in July 2020. Participants worked in a range of settings, including generic and specialist CAMH services, as well as having varying levels of experience working with children in local authority care. After a presentation of the research findings, participants were divided into groups and asked to discuss the findings in relation to their own practice and experiences, and then feedback to the wider group. Overall, the findings resonated well with most participants, particularly the description of the different identities, and balancing a focus between the child's internal and external worlds. Several participants highlighted their perception that the setting under study appeared to be 'privileged' in comparison to their workplaces: firstly, because child psychotherapy was respected and valued by both the CAMHS and social care teams; secondly, because the CAMHS team had the flexibility to work with children for extended time periods; and thirdly, because there were two child psychotherapists in the service. Several participants, operating as a lone child psychotherapist in their CAMH service, commented that they found it more difficult to hold onto their discipline-specific identity without the support of another child psychotherapist in the team. Participants thought that the smallness of the CAMHS team described in this study was potentially beneficial in reducing the potential for tensions to appear between

colleagues; thus facilitating the 'CAMHS team member' identity, potentially not as strong in larger, generic CAMH services. There was a sense, therefore, of a spectrum of experiences amongst child psychotherapists working in this field, with the setting in this study perceived as being at the more 'privileged' end of the spectrum. This also resonates with Briggs (2018) who perceives that child psychotherapy has lost 'favour' within CAMH services generally, with other disciplines being valued over and above child psychotherapy. Overall feedback received from the webinar thus suggests that while the findings of the study did largely resonate with child psychotherapists working in this field, there is a need for further research to explore practice in other settings, such as large, generic CAMH services, where there may be a different balance between the three identities described in this study.

5.5.4 Strengths and limitations of the study

This study used an ethnographic case study design, an advantage of which is an in-depth, rich analysis of the setting and participants under study. This methodology also allowed the development of a conceptual, integrated theory, grounded in the data. Another advantage of ethnographic research is its emphasis on the emic, or insiders' perspective, giving a voice to the participants under study. Arguably a disadvantage of the main data collection method used in this study – observation – is that participants' natural behaviour is inevitably altered by the researchers' presence. However, as described in the Methods section, measures were put in place to mitigate effects of this. Furthermore, this study utilised the following procedures to prioritise the participants' perspective: observing participants closely over a period of several months; exploring participants views through informal and formal interviewing; the practice of reflexivity, considering my own assumptions and biases; and a member-check as part of the analysis process.

The study also has several limitations. Problems with generalisability of the findings outside the setting under study have already been discussed in section 5.5.3. Due to ethical constraints imposed by the local authority, this study had a focus on the child psychotherapists' work with social workers and other professionals in the professional network. No consultations with foster carers were observed, nor

interviews with children or foster carers conducted. During CAMHS team meetings and their consultations with social workers, the child psychotherapists frequently spoke about their work with foster carers, and this clearly formed an integral component of their role in this setting, essentially missing from this study's findings. Future research could examine this aspect of their working in greater detail, potentially interviewing foster carers about their experiences of working with psychoanalytic child psychotherapists, and perceptions of their role.

5.5.5 Implications

The findings of this study have implications for knowledge and practice, for both the child psychotherapy profession, and allied professions including social care. This study highlights the specific contribution of psychoanalytic child psychotherapy to working in both a multi-disciplinary CAMHS team, and more widely to multi-agency working with services including social care. Although the child psychotherapists' direct work with children and young people was not observed, and therefore no implications for this aspect of their practice can be drawn, the findings have implications for how social care can best make use of child psychotherapists' conceptual knowledge. This is particularly regarding the attention the child psychotherapists paid to the child's emotional and psychological life, connecting the child's internal world with their external world. The child psychotherapists' role of attending to social workers' feelings and anxieties, through an understanding of how professionals may protect themselves from the feelings generated by the painful nature of the work, and how this can create risks to both the individual worker and task of the organisation, was also valued by social workers. These findings suggest a role for psychoanalytic child psychotherapists, working in the field of children in local authority care, to be involved in facilitating reflective practice spaces. This implication contrasts with the shifting focus that the CAMHS team reported in their service, with the local authority wanting them to primarily provide individual therapy. These findings suggest the unique perspective that psychoanalytic child psychotherapists have to offer to consultation and reflective practice for social workers.

The findings also have implications for how professionals working in the children in local authority care field can negotiate collaborative working relationships. Having co-located CAMHS and social care teams was perceived as important in facilitating good working relationships, as all the 'little decisions' on cases could be thought through on a day-to-day basis, and team members thought it gave them a good understanding of the other agencies' position and responsibilities. The findings also showed the child psychotherapists' unique perspective on the importance of joined up thinking between agencies; that when the network functions effectively around the child, it brings the fractured pieces of the child's experience together, enabling the child to feel held by the professionals caring for them. As part of a 'member check', the study's findings were presented virtually to the participating social care team in September 2020, following a period of lockdown in the UK during the Covid-19 pandemic. Feedback received from the team following this period of remote working emphasised the importance they placed on the 'informal' elements of consultation with the child psychotherapists, given that this was now missing from their practice. In future, there is therefore potentially a need for research to establish how effective multi-agency working can be promoted, given the possibility of increased remote working following the pandemic.

The findings of this study also suggest the potential benefits of having at least two child psychotherapists in a multi-disciplinary team, in terms of strengthening child psychotherapists' sense of discipline-specific professional identity. Briggs (2018) has written about what he perceives as a loss of containment within CAMH services generally, with a shift towards not providing supervision appropriate for the level of complexity that clinicians often encounter in their practice. Given the complexities of the three identities outlined in this study, as well as the various roles and processes they engaged in with network professionals, the need for robust supervision for child psychotherapists operating within the children in local authority care field is paramount.

Given that this is a case study, any implications of these findings are drawn tentatively, and future research could replicate this study in similar settings for firmer conclusions to be made (Yin, 2009). Furthermore, future qualitative research could explore child psychotherapists' work with other agencies including education and health professionals in greater detail, to distinguish similarities or differences in their role and approach to working with social care.

5.5.6 Summary and conclusion

This chapter detailed the third and final study of the research. The main finding was that child psychotherapists adopted three aspects of their professional identity in their role in a children's social care setting, presented as a grounded theory of *Integrating Professional Identities*. The study drew on theories of professional identity to explain the child psychotherapists' identity in this setting, demonstrating that it was fluid, mostly integrated, and constructed from their interactions with those in their working environment. This study's findings demonstrate the child psychotherapists' distinctive voice and place in a multi-disciplinary team, and when working with other services in a multi-agency setting.

6 General Discussion

6.1 Introduction

The overall aim of this thesis was to explore psychoanalytic ways of working with children in local authority care and the role of UK psychoanalytic child psychotherapists working in this field. Following a review of the literature, the first empirical study was a national survey of UK psychoanalytic child psychotherapists about their work with looked after and adopted children. A qualitative follow-up study was then conducted, exploring child psychotherapists' role as consultant to the professional network around children in local authority care. The third study was an in-depth case study of child psychotherapy in a specialist multi-disciplinary LAC CAMHS team, in a children's social care setting. This final chapter will review the main findings and conclusions of the studies collectively, as well as discussing limitations and implications for future research, clinical practice, and mental health service delivery.

6.2 Main findings and their relevance to the existing literature

Prior to commencing this thesis, there was only very little research assessing the use and contribution of psychoanalytic child psychotherapy to work with children in local authority care (see Boston & Lush, 1994; Boston et al., 2009). In the first half of the twentieth century, psychoanalytic work with children was originally developed for those with 'neurotic' problems, and the appropriateness of this approach for children with early histories of trauma or maltreatment was unclear. As psychoanalytic child therapy took up a place in general Child Guidance Clinics in the UK from the 1950s onwards, therapists were increasingly challenged to work with children with histories of trauma, maltreatment and neglect, and had to find ways to modify their technique to ensure it was suitable (Rosenfeld & Sprince, 1963; 1965). Nowadays, child psychotherapy is used in routine clinical practice with children with traumatic histories, including those in the care system. Despite this, the extent to which psychoanalytic child psychotherapy was being used with children in local authority

care in the UK had not been studied, as well as the nature, range, and context of treatment. Empirical research was also lacking on the other aspects of child psychotherapists' work with children in local authority care, including work with the professional network and foster carers. These gaps in knowledge were the starting points for the research undertaken in this thesis.

6.2.1 Summary of main findings

This section will present a brief summary of the three studies, before moving onto a discussion of the key findings, across all studies, in subsequent sections.

The first empirical study of this thesis explored the nature and provision of psychoanalytic models of intervention for looked after and adopted children in the UK. A total of 215 completed responses were received from ACP registered child psychotherapists (24.5% response rate). Most child psychotherapists surveyed were doing work with these children in some capacity (87.9%). Although the largest proportion of respondents were working in generic CAMHS settings, many were working in alternative services, such as specialist LAC services within CAMHS or social services, or in private practice. This is pertinent given the literature recommending specialist, multi-agency services as effective practice for children in local authority care (Callaghan et al., 2004; Golding, 2010; McAuley & Young, 2006; Ward et al., 2002) and demonstrates that child psychotherapists are contributing to these services in routine clinical practice.

Those surveyed were conducting a wide range of activities regarding these children, commonly including assessment, direct therapy, work with foster carers and adoptive parents, and consultation with the professional network. In terms of the direct therapeutic work; long-term, open-ended, weekly individual psychotherapy was the most common type conducted with these children. However, brief and short-term psychotherapy was also being conducted by respondents, in contrast to the typical perception of child psychotherapy as a long-term or open-ended treatment approach (Petit & Midgley, 2008). Thematic analysis of qualitative data demonstrated respondents' widespread perception of the complexity of problems amongst these children attending psychotherapy. Many respondents also placed emphasis on work with the professional network and foster carers / adoptive parents,

as well as seeing these as an area of development for child psychotherapy services. This finding focused the next steps of the research, in terms of considering aspects of child psychotherapists' practice outside the therapy room. No research had previously explored these aspects of child psychotherapists' practice in-depth, particularly how they understood their work with the network.

Building on this finding, the second empirical study was a qualitative study of child psychotherapists (n=9) regarding their role as consultant to foster carers and the professional network around the child. Thematic analysis identified three themes concerning tensions child psychotherapists held within themselves whilst consulting to the professional network. Participants experienced a dilemma between what was demanded of them by network professionals (often for the child to receive individual therapy) versus what they felt they could offer (often wanting a more network-led approach). They also experienced a tension around the way the system is organised – primarily around targets – versus what they thought may be in the best interests of the child and network. Finally, they discussed a tension between whether their consultant role fits a generic model of reflective practice similar to that offered by professionals from other disciplines, or whether the psychoanalytic approach brings something distinctive to this model of consultation. Most participants thought the psychoanalytic approach offered something unique in terms of providing a space for professionals to begin to tolerate uncertainty, for anxieties to be made conscious and reflected upon, and for the network to make decisions collaboratively, rather than being based on a defensive need to solve unbearable situations. Many participants were using on a model of working with foster carers and other professionals that used ideas from Bion's theory of thinking (1961) in addition to having some similarities to a mentalization-based approach (Bateman & Fonagy, 2006). However, this study did not identify how such an approach functions in the context of multi-disciplinary and multi-agency working, which the third study aimed to investigate.

The third study explored how psychoanalytic child psychotherapy functions within a specialist children's social care setting, including how they positioned themselves in a multi-disciplinary CAMHS team and a multi-agency setting. Given study two's focus on the perspectives of child psychotherapists, study three also used researcher observation and considered the views of social care professionals. This enabled exploration of whether child psychotherapists' views are echoed amongst other professionals, including those who are recipients of consultations.

Ethnographic methods were used to collect data, through participant observation, informal, and formal, interviewing. The findings were presented as a grounded theory of *Integrating Professional Identities*. The main finding was that the child psychotherapists balanced three elements of their professional identity in their role in this setting: a discipline-specific identity; a CAMHS team member identity; and a professional network member identity. Their role involved engaging in a variety of processes, which ultimately aimed to place the child's emotional and psychological life, as they understood it, at the centre of social cares' planning and practice. The child psychotherapists shifted between identities while engaging in these processes. The analysis demonstrated the intended consequences of the child psychotherapists' actions, while simultaneously specifying how the setting they operated within at times limited them in achieving what they aimed to do. The theory argues that to be effective in their role in this setting, the child psychotherapists need to have integrated, or found a balance between, the three elements of their professional identity.

In the sections that follow, I will draw out the key issues arising from findings across the studies. These will be organized around three questions, which will also situate the findings within existing theories and literature.

6.2.2 Is child psychotherapy in the context of children in local authority care predominantly about direct work?

Traditionally, the principal role of UK child psychotherapists is perceived as providing individual therapy for children and young people, often in NHS CAMH settings (Petit & Midgley, 2008). Thematic analysis in study 1 highlighted child psychotherapists' perceptions about the unique contribution that psychoanalytic child psychotherapy can make to addressing the mental health needs of some children in local authority care in terms of direct therapeutic work. The therapeutic setting was perceived as an appropriate environment for addressing some of these children's need for consistency, with the emphasis on a safe, reliable, predictable setting. Child psychotherapy's emphasis on the relational approach, with the transference relationship being the vehicle of change, was viewed as particularly important for children with experience of early maltreatment or abuse, in terms of developing a

trusting relationship with a benevolent adult figure. The focus on unconscious ways of relating, in comparison to other treatment approaches, was also seen as appropriate for some of these children, who may struggle to verbalise their thoughts and feelings. Furthermore, the characteristics of the therapist were viewed as making this approach suitable, with emphasis on the therapist using their observational skills and developmental approach to meticulously attend to the child's communications. Finally, the intensity and depth of the intervention was spoken about as making child psychotherapy unique. Many survey respondents commented that they felt that this approach, in contrast to other treatment approaches, worked at making deep seated changes rather than just reducing symptoms, which were often needed by some of these most vulnerable children. These included internal changes in the child and an opportunity to change their ways of relating to others. These findings resonate with the clinical literature, for example that the provision of regular, reliable therapy sessions provides a sense of continuity which may have been previously missing from these children's lives (Canham, 1999; Hunter-Smallbone, 2009). This study's findings build on this literature by highlighting child psychotherapists' perception about the unique contribution that psychoanalytic therapy can make to therapeutic work with these children, in comparison to other treatment approaches. However, both the clinical literature, and the survey reported here, rely on child psychotherapists' own reports. A limitation is that there is no external evaluation or triangulation of findings in other ways than by the views of those trained and practising this approach. Therefore, future research could triangulate this with the views of other mental health clinicians, service users, or professionals in the child's care network. Furthermore, further research is required on the effectiveness of psychoanalytic therapy as a mental health treatment for children in local authority care; this will be discussed further in section 6.3.2.

Several survey respondents spoke about child psychotherapy being a limited resource, and their perception that their therapeutic work is viewed as a 'last resort' option when other treatments have failed. This finding has been noted by a previous study (Kam & Midgley, 2006) and an earlier survey of the profession regarding child psychotherapy practice more generally (Beedle & Payne, 1987) – suggesting a need for the profession to change services' and commissioners' perceptions about child psychotherapy's use in comparison to other treatments. Potentially this perception stems from perceptions within multi-disciplinary teams about child psychotherapy

being 'precious', 'mysterious', and rigid in its way of working (Kam & Midgley, 2006, pp. 34-35). Current treatment guidelines for children and young people also focus on brief, symptom-oriented treatment for one disorder (Weisz et al., 2018).

Despite perceptions within study 1 that child psychotherapy was a suitable therapeutic treatment for some children in local authority care, the analysis identified that child psychotherapists' work around these children extended far beyond the 'traditional' perception of their role. In all three studies, work with foster carers, and the professional network, were perceived as often equally important, if not more important, than direct work with the child. Many child psychotherapists perceived that by working with the network around the child, the therapeutic need could often be met without the need to always undertake individual therapy. This finding was somewhat unexpected, given that the vast majority of the clinical literature reviewed prior to undertaking the study focused on individual therapy with children in local authority care (e.g. Boston & Szur, 1983; Jackson, 2004; Lanyado, 2003; Marsoni, 2006; Rustin, 2006), with only limited consideration given to child psychotherapists' work with the network around the child (e.g. Emanuel, 2002; Hunter, 2001; Rocco-Briggs, 2008).

In both studies 1 and 2, analysis suggested the need to recognise that therapy may not always be the preferred course of action for some children, or at a given timepoint in their lives. It was clear that it could be difficult to engage many of these children in therapy, with respondents reporting the child could often present as highly mistrustful and testing the boundaries of the therapeutic relationship. This finding perhaps links to research around the role of attachment and early adversity in the development of epistemic trust, with survey respondents indicating high levels of epistemic mistrust amongst this group of children (Fonagy et al., 2015; Fonagy et al., 2016).

In study 1, analysis identified a common dilemma about offering therapy to children when the service was not able to offer the level of therapeutic input perceived as necessary. Concerns were raised that for the most disturbed children, even a minimum of weekly sessions were not enough to treat the depths of their problems, with more frequent, intensive work required in these cases. Relatedly, some respondents felt that short-term psychotherapy could be detrimental for children with experiences of loss and abandonment, replicating their experiences of being left. Many respondents placed emphasis on adopting a very gradual approach

to the developing therapeutic relationship, going at the child's pace, stating that it can take several months to engage these children. The findings are consistent with previous literature about the complexities of problems amongst this population (DeJong, 2010), as well as psychoanalytic literature about these children's presentation in therapy sessions (Hughes, 1999; Marsoni, 2006) and proposals that short-term interventions may be insufficient to address the depths of their problems (Rustin, 2001, 2006). This research adds to this literature by demonstrating perceptions amongst a proportion of child psychotherapists that their service was unable to offer the level of support they thought is required for some of the most disturbed children, due to service remit limitations or pressure to discharge cases. In contrast, observations of the specialist LAC CAMHS service who participated in study 3 showed that they had more flexibility to work with children for longer time periods, using a distinct 'phase-in-phase-out' approach to keep cases open even when therapy was not actively being undertaken. Whilst the child psychotherapists in this service thought this way of working was advantageous – for the children they worked with; for the social care team in terms of continuing to access consultations on cases where therapy was not active; and for their own CAMHS team in terms of holding a child's history over long periods; they acknowledged the negative impact this had on their activity monitoring and referral figures. Within UK mental health services, there has been a shift towards routinely offering time-limited, maximum once weekly sessions to children and young people (Bent-Hazelwood, 2020). This arguably links to increased demands on services but decreasing levels of resources and investment (Royal College of Psychiatrists, 2013). Bent-Hazelwood (2020, p.410) describes the potential impact of this mode of working on psychoanalytic practice within multi-disciplinary teams, arguing there is a danger that 'more intense [and long-term] psychotherapy becomes an alien, impossible concept within publicly funded institutions.' If long-term psychotherapy – and intense, frequent work for some of the most disturbed children – is the preferred treatment for children in local authority care, there is a need for the profession to convince services and commissioners of the value of investing in this. There is already research to suggest that receiving intensive psychotherapy can lessen reliance on other services (Robertson, 2007) and that longer treatment duration of psychodynamic therapy is positively correlated with improvement in outcomes for complex disorders in adults (Leichsenring & Rabung, 2011). Further research is needed into potential benefits of

long-term, and / or intensive psychotherapy for some children in local authority care to enable the child psychotherapy profession to demonstrate the merits of funding this.

Analysis in studies 1 and 2 identified instances in which therapy may be potentially unsuitable for children lacking stability in their lives, for example those just entering the care system, going through court proceedings, or in unstable placements. There was a consensus amongst child psychotherapists across the two studies that therapy was most appropriate for children in stable, often long-term placements, with foster carers who were able to support them through the therapy. Several child psychotherapists interviewed in study 2 perceived that for children lacking stability, they may *need* to hold onto their defences at this time as a means of coping with uncertainty, and it could be detrimental to ask them to unpack them within a therapeutic setting. They linked this to a hierarchy of needs, in which they perceived that the priority for the child is to feel settled and safe in their placement before therapeutic work can be undertaken. A child's sense of 'readiness' to undertake psychoanalytic therapy has been noted by previous literature (Kam & Midgley, 2006, p.39), however these studies' findings demonstrate specific considerations needed when assessing suitability for children in local authority care; namely that the service is able to offer the length of work required to address the child's problems, and that they are in a stable home environment and supported to attend therapy by those looking after them.

When the conditions were not perceived as right for therapy, child psychotherapists spoke about wanting to offer alternative approaches; often creating a thinking space *around* the child with the foster carers and network professionals. They felt that their focus was about offering a thoughtful, consultative capacity to the professionals who hold responsibility for the child, before (or instead of) adding another professional to the child's network by undertaking therapy. Many child psychotherapists stated that their approach was flexible depending on the individual child, and therefore it was not necessarily possible to distinguish between whether network working was always a precursor to, or alternative, to therapy. However, several child psychotherapists across all three studies were using a model of working which always began with consultation with the network, prior to considering a recommendation for therapy. This period was used to gather information about the child's history and relationships, identify support available within the child's

professional network and home environment, and recognise any tensions or anxieties existing amongst professionals. Some child psychotherapists spoke about their initial role of receiving, and making sense of, anxiety from the network, before even beginning to think about a course of action for the child. In some cases, they thought it was more helpful to think with the network about disruptive factors occurring either amongst professionals or within the foster caring situation, rather than locating the problems solely within the child. This consultation period may mean that they identified the provision of existing support within the network itself, such as a stable foster carer or school mentor. They hoped that by working to bolster those existing supports, they could provide a more ordinary experience for the child, in which they did not have to attend therapy. Across the studies, many child psychotherapists spoke about psychotherapeutic work with foster carers as helping carers to understand what the child may be communicating through their behaviour, as well as the impact on the carer themselves and feelings that may be aroused in them. These findings share commonalities with the clinical literature, which has described the child psychotherapists' role as consultant to foster carers (Ironsides, 2009, 2012; Rocco-Briggs, 2008). This research builds on this literature by proposing that consultation with the network and foster carers is a distinguishing feature of the work of child psychotherapists within this field, distinct from work with birth families. Even in cases where therapy was recommended, many child psychotherapists spoke about a period of working with the network before approaching the point of starting therapy, for example helping the system to support the child to attend therapy.

Across the studies, it was clear that many child psychotherapists were not always able to offer the approach they deemed as most appropriate for the child. Despite extensive recognition that work with foster carers was essential, it was also largely perceived as being undervalued by services or constrained by resource limitations. In contrast, within the LAC CAMH service who participated in study 3, field notes recorded that a substantial proportion of their work included consultation with foster carers, suggesting that within this specialist service, work with carers was supported by commissioners. Despite this support, the CAMHS team had faced recent cutbacks to training packages they previously offered to carers.

There was also a widespread belief by child psychotherapists across all three studies that consultation work with the professional network was under-funded and

under-resourced. In study 2, thematic analysis identified that participants experienced a tension around what they felt they could offer versus what was often demanded by the network – namely, for the child to receive individual therapy. Several child psychotherapists reported that if they offered consultative work to social services, this was sometimes perceived as them withholding the service that social workers most wanted; a finding which has been noted by previous literature (Emanuel, 2002). In study 3, analysis suggested there was a mismatch between the work undertaken by the child psychotherapists versus the activity they were monitored on; while the bulk of their time was spent on consultation with the network, often informal, they were monitored on the number of children seen each month in individual therapy. The CAMHS team perceived this activity monitoring to reflect the wish by commissioners that they focus on the aspects of their role which involved directly working with children. Interviews with social care managers in study 3 similarly revealed a perception that, although they saw one aspect of the child psychotherapists' role as providing consultation to social workers, principally their role was viewed as providing individual therapy. This was explained as a belief about the distinction between the role of the social worker – including co-ordinating the network, care planning, pathway planning, as well as some direct work with children – and the role of the child psychotherapist; to work with and hold emotional feeling. This was viewed as a different skillset to that of social workers, which child psychotherapists had expertise in. Arguably this could be viewed as a contradiction within the context of resource-stretched services, for which individual therapy incurs a greater financial cost than a consultation-led approach. Within the specific setting studied in study 3, this contradiction can be explained by the recent introduction of a local authority employed systemic clinical team, who took on the bulk of consultation work with social workers. The analysis suggested a perception held by management that child psychotherapy was individual-facing (and therefore suited to the therapeutic aspects of practice), whereas systemic practice was outward-facing (and therefore suited to the consultation work). Future research could explore whether the views of Service Managers in study 3 are echoed by local authority managers from other services, including those without an embedded culture of systemic practice. These findings also suggest a need for child psychotherapy to change the 'public face' of the profession, including the ways it presents its work to services and commissioners, with more of a focus on consultation-led services.

Collectively, these findings suggest that, whilst there is a perception amongst many child psychotherapists that the psychoanalytic approach is a suitable treatment method for some children in local authority care, the conditions needed to be right for therapy. Analysis demonstrated that a distinctive element of the child psychotherapists' work within this field was consultation with the professional network and work with foster carers. However, concerns were raised that these aspects of their work were undervalued by services and commissioners. Given these findings, studies 2 and 3 particularly focused on the reasons that may underlie these differences in perception about the child psychotherapists' role; the child psychotherapists' contribution to reflective practice; and in study 3, considering the views of professionals independent of child psychotherapists, as well as researcher observation of practice.

6.2.3 What contribution can psychoanalytic child psychotherapy make to work with the professional network around children in local authority care and reflective practice?

The findings of studies 2 and 3 propose that child psychotherapy firstly has a place in aiming to keep the child's emotional and psychological life at the forefront of network thinking. The grounded theory analysis in study 3 identified that child psychotherapists understood the complex connection between a child's past experiences and current behaviour and responses to relationships and aimed to consider this in network planning. This finding resonates with practice-based clinical literature, for example Rocco-Briggs' (2008) assertion that children's expectations about ways of relating to others are often impacted by previous abusive experiences, and that child psychotherapists can work with network professionals to understand how this dynamic may be replicated in current relationships. Study 3's analysis builds on this literature by identifying that the child psychotherapists often engaged in a process of translating their discipline-specific knowledge into something that social workers and other professionals could use and make sense of. In interviews, some social workers also recognised this and perceived their presence as a 'reminder to focus on the child', in a role with many other competing tasks and priorities.

Furthermore, the findings of studies 2 and 3 propose that psychoanalytic thinking can contribute to understanding dynamics occurring within networks, particularly the ways in which unconscious anxiety may manifest itself and impact detrimentally on network functioning. Observations of consultations between child psychotherapists and social workers in study 3 suggested there was conscious and unconscious anxiety amongst social work professionals. Several social workers also acknowledged this during interviews. Child psychotherapists in studies 2 and 3 perceived this anxiety could lead to reduced thinking capacities regarding the child's needs. They described a framework for understanding how these networks managed their anxiety as defensive strategies, including a blame culture and splitting across services and within teams and a common desire to get the child into therapy quickly so that the therapist will 'fix' them. This may explain the disparity between how some social workers in study 3 viewed the child psychotherapists' role (as mental health experts who principally provided therapy) and what child psychotherapists were often attempting to provide (often a thinking space around the child). Child psychotherapists interviewed in study 2 felt that the effects of this anxiety hindered professionals' abilities to think about the child's needs and perspective, with the child often being described as 'lost' amongst network thinking. These findings are congruent with previous psychoanalytic literature, including literature surrounding organisational defences against anxiety in healthcare settings (e.g. Hinshelwood & Skogstad, 2000; Menzies-Lyth, 1960) and the clinical child psychotherapy literature (e.g. Emanuel, 2002; Rocco-Briggs, 2008). Studies 2 and 3's findings suggest that these organisational defences are displayed by professionals working outside the healthcare sector, namely in social care settings, which has also been noted by studies in the social work literature (Ferguson, 2018; Lees et al., 2013). The findings of the empirical studies of this thesis suggest that the child psychotherapist has a role to play in providing insight into these defences.

A key aspect of the analysis from studies 2 and 3 was that child psychotherapists recognised where they felt anxiety was occurring within the system, and how it was being managed. They then invited these anxieties to be named and thought about. The findings propose that the psychoanalytic approach has something unique to offer to consultation with the professional network; namely a distinctive type of reflective practice to those offered by other models, particularly those in the social work literature. Whereas other models engage in reflection as a

process to producing subsequent action (e.g. action learning sets, see Abbott & Taylor, 2013), the 'action' in this practice is the containment of conscious and unconscious anxieties (drawing on Bion's (1962) concept of container-contained). This form of consultation also appears distinct from other psychoanalytic, case-based discussions, such as work discussion groups (Rustin & Bradley, 2008), or psychological models in which explanations are provided of the child's behaviour and behavioural strategies encouraged. The form of consultancy described by child psychotherapists, and observed during consultation sessions in study 3, appears to be more than simply offering a reflective space, but is an active process in which the child psychotherapist responds to professionals' communications dynamically in the here-and-now. This links to Cregeen's (2008) proposal that the child psychotherapist is engaging with the disturbance and relational processes occurring between professionals within the consultation itself, rather than at one step removed by discussing specific cases or giving explanations of behaviour. The proposed mechanism of change is therefore that professionals develop an understanding of how they may protect themselves from the feelings generated by the nature of the work, and how these can create risks to both the individual and the task of the organisation. Having an awareness of this may 'free up' their thinking capacity, allowing them to tolerate the uncertainty inherent in these highly emotive working environments, connect with their own feelings; in turn helping them to think about the child's needs and make decisions collaboratively with the network.

Studies 2 and 3's analysis demonstrates that the child psychotherapists also engaged in processes that were sometimes action-focused, often designed to alter network planning or decision-making. This included investigating (and challenging where necessary) the processes that led to decisions being made, often unpicking external pressures. In study 2, participants experienced a sense of tension between how the system is organised, and their role which may be to sometimes question whether this organisation is in the best interests of the child. For example, while placement stability and permanence may be viewed as the 'holy grail' by services, their role sometimes involved questioning this when they felt it was detrimental for the child to remain with a foster carer. Their consultant role also included encouraging network professionals to see the value in the work they already do, rather than adding another professional to the child's life by always undertaking therapy. This was triangulated with, and supported by, some social workers

interviewed in study 3, who said that consultations with a child psychotherapist could lead to them having a greater sense of agency over their decision-making, as the professionals with corporate parent responsibility. This shares commonalities with mentalization-based approaches for hard-to-reach youth (the AMBIT model; Bevington et al., 2013), namely that team and network functioning is supported through ‘scaffolding’ existing relationships in networks – by encouraging network members to support a key professionals’ mentalizing.

6.2.4 How can child psychotherapists integrate themselves into multi-disciplinary teams and multi-agency settings, whilst retaining their distinct sense of professional identity?

Within the context of ‘creeping genericism’ of mental health services generally, including CAMHS, there is an increasing need for individual disciplines to establish their distinct contribution (Brown et al., 2000; Hill-Smith et al., 2012). Kam and Midgley (2006) raised the question of how child psychotherapists can integrate themselves into multi-disciplinary teams whilst retaining their own unique contribution to practice, particularly as clinicians in their study regarded some of child psychotherapy’s attributes as an ‘unaffordable luxury’ in a NHS CAMH setting (p. 41).

Study 3’s findings propose how this can be achieved within a specific setting, namely a specialist LAC CAMHS team, embedded in a children’s social care setting. The analysis identified that the two child psychotherapists adopted and shifted between two elements of their professional identity; their discipline-specific identity as a psychoanalytic child psychotherapist, and their identity as a member of the CAMHS team. Whilst their discipline-specific identity was their core identity, and often informed their discussions with the other child psychotherapist and their multi-disciplinary case discussions, they drew on their identity as a CAMHS team member – shared with the other clinicians – as a means of integrating themselves into a multi-disciplinary team. This identity allowed team members to process feelings surrounding these children and their circumstances, served as a strategy for minimising anxiety induced by the uncertainties of their work setting, and demonstrated a joint team viewpoint based on psychological understanding of the

child. In contrast to previous literature suggesting that clinicians may experience 'role blurring' or 'role confusion' within the context of increasing genericism of services (Atkinson et al., 2007), this study found that the child psychotherapists had a very strong sense of their distinct professional identity, whilst also actively choosing to adopt their CAMHS team member identity as a positive means of identifying with team members. This study demonstrated the conditions within which the balance between these identities was struck and argues that to be effective in their role in the team, the child psychotherapists needed to integrate these identities within themselves. This integration was supported by the professional confidence the child psychotherapists had in their role and identity, which the analysis argues stemmed from: their psychoanalytic theoretical training and knowledge; their joint working practice with the other child psychotherapist in the team, strengthening their discipline-specific identity; and also the relationships between CAMHS team members, built on friendship, respect, and camaraderie.

This study also identified a third element of the child psychotherapists' professional identity, as a member of the professional network, that they used to integrate themselves into a multi-agency setting. Whilst their core, discipline-specific identity informed their communications with social workers (primarily drawing on theoretical frameworks around splitting, projection, and organisational defences), they often engaged in a process of translating their theoretical knowledge into something that was accessible and usable by social workers. The findings demonstrate the child psychotherapists' distinctive perception that when the network functions effectively around the child, it brings the fractured pieces of the child's experience (which may have been split off into different professionals) together, enabling the child to feel held by the network, akin to a parental unit. Despite using this aspect of their identity, the child psychotherapists were prepared to shift to other parts of their identity when they disagreed with the perspective of other network professionals, thus retaining all three aspects of their professional self.

This is the first research study to explore how child psychotherapists function as part of a specialist CAMHS team, in a children's social care setting; demonstrating how the child psychotherapists operated both in terms of their discipline-specific contribution to practice, and their role and voice in multi-disciplinary and multi-agency collaboration around children in local authority care.

6.3 Implications of findings

This section will discuss the implications of the main findings for practice and future research.

6.3.1 *Implications for practice*

The research undertaken in this thesis has important implications for practice, both for the child psychotherapy profession and allied professions including social care. The findings have implications for how social care can best make use of child psychotherapists' conceptual knowledge. This is particularly in relation to child psychotherapists' understanding of the child's internal world, its impact on behaviour and their relationships to others, and what the child may be communicating through their actions. Furthermore, their understanding of how social workers may protect themselves from the feelings generated by the nature of the work, and that – unless managed – these defences can create risks to both the individual worker and the task of the organisation. This suggests that child psychotherapists, working in the field of children in local authority care, may offer something distinct to reflective practice spaces for social workers and other professionals, drawing on different theoretical knowledge and frameworks to clinicians from other disciplines, and offering a different type of 'action' to other models of reflective practice, which is the containment of conscious and unconscious anxieties.

The findings also suggest a need for social care to recognise when therapy is not always the most appropriate intervention for some of these children, or at specific timepoints in their lives. On some occasions, child psychotherapists may be better placed to provide a thoughtful, consultative capacity to the professionals who hold key responsibility for the child, rather than adding another professional to the child's network by undertaking therapy. Similarly in some instances, child psychotherapists may be best placed to work directly with the foster carer as a means of supporting and strengthening their relationship with the child, and the therapeutic need can be met without the need to always undertake individual child therapy.

To work effectively alongside social care, the child psychotherapy profession needs to have a good understanding of social cares' needs and pressures, as well

as potential conflicts or tensions inherent between services in this field of practice. This has implications for child psychotherapy professional training. Within both academic modules concerning child psychotherapists' work with children in local authority care, and clinical placements whereby trainees are actively working with these children; training should include a core element of consultation to the professional network and foster carers. This should include the complexities of working with large networks, who often have different agendas and priorities; dynamics that can occur within networks, including the manifestation of unconscious anxieties through splits and tensions between services; and ways of managing these tensions in order to work effectively alongside other professionals.

The findings also have implications for qualified child psychotherapists already practising in this field. There is a need to recognise that social care, as the corporate parents for the child, may at times have different priorities to them as mental health professionals. To facilitate good working relationships between agencies, it is necessary for child psychotherapists to consider the timeliness of interpretations or interventions. For example, as demonstrated by study 3's findings, social workers may not always be receptive to child psychotherapists' immediate interventions at times of crisis or when there is a pressure to act, such as an unexpected placement breakdown. It may be that at times of crisis social workers need to hold on to their defences in order to keep practising, by focusing on the practical tasks at hand. This shares commonalities with other theories and treatments, such as MBT; when a patient is in a non-mentalizing or high arousal state, the therapist first needs to decrease the level of arousal through 'safe' interventions, such as offering support and empathy. Further interventions – including offering a different perspective – potentially increase arousal and are therefore only used once mentalizing is reintroduced (Bateman & Fonagy, 2013). For child psychotherapists working alongside social workers in the midst of crisis situations, the provision of sustained, regular thinking spaces may be a more pertinent intervention in helping them to develop reflective practice skills, rather than challenging or offering an alternative perspective at the time of crisis. Potentially they can then apply principles of 'thinking prior to action' (Cregeen, 2008; p. 186) in later crisis situations.

At a service delivery and policy level, many child psychotherapists who participated in the research advocated the use of flexible approaches for this

population of children, adapting their models of working dependent on individual need. For example, in study 3, the specialist LAC CAMH service used a 'phase-in-phase-out' approach rather than closing and reopening cases. This contrasts with typical practice within mental health services, which often recommend a specific number of sessions (Warnick et al., 2012), with pressure to then discharge cases common in resource-limited services (Owens & Charles, 2016). Using a 'phase-in-phase-out' approach may benefit this specific population of children and young people – for whom therapy may not be appropriate at various timepoints in their lives, but may value the continuity of having an 'open door' to return to at a later stage. Furthermore, this approach may benefit social workers and other network professionals in terms of having mental health services with a rich understanding of a child's history, who are available for consultation on cases even when therapy is not actively being undertaken. For the mental health service itself, using such an approach may lead to less re-referrals to services. While this conclusion can only be made tentatively given that study 3 was a case study of child psychotherapy in a specific setting, this implication suggests a need for future research studies to establish the feasibility and cost-effectiveness of using such an approach more widely within targeted mental health services for children in local authority care.

The research presented in this thesis also helps to understand some of the potential benefits of co-located services around children in local authority care. In study 3, having co-located CAMHS and social care teams was perceived by both teams as important in facilitating good working relationships. The findings of this study suggest that co-location of services can enable agencies to have a good understanding of each other's position and responsibilities, and foster the use of 'informal' consultation – across desks and in corridors – enabling all the 'little decisions' on cases to be thought through as joined up agencies on a day-by-day basis. This research also provides understanding of some challenges of co-located CAMHS and social care teams, particularly around the somewhat limited authority of clinical responsibility compared to corporate parent responsibility within this setting. The findings suggest that these challenges can be managed as a process of negotiation between agencies, and that having relationships built on trust and mutual respect can go some way to alleviating difficulties.

6.3.2 Implications for future research

A major research implication concerns the need to establish the evidence-base for child psychotherapy's individual therapeutic work with children in local authority care. Preliminary evidence provided by study 1 highlights child psychotherapists' perceptions that psychoanalytic therapy is a suitable treatment method for some of these children, but that it is often chosen as a 'last resort' option when other treatments have failed. Although psychoanalytic therapy for children and adolescents has a growing evidence base, there is still a lack of high-quality studies assessing its effectiveness as a treatment method, particularly concerning children in local authority care who are a diagnostically diverse group (Midgley et al., 2017; Midgley & Kennedy, 2011). There is only one UK study exploring effects of psychoanalytic treatment specifically amongst children in local authority care (The Tavistock study of children in foster care; Boston et al., 1991; Boston et al., 2009; Boston & Lush, 1994; Lush et al., 1998). Although the study had promising findings in that most children improved by the end of treatment, the lack of control group and small sample size limits the conclusions that can be drawn in terms of effectiveness. To test the perceptions of many child psychotherapists who participated in study 1 of this thesis, there is a need for future research to assess the effectiveness of psychoanalytic therapy for children in local authority care, using RCT designs where possible. However, it is important to acknowledge the difficulties of conducting this type of research with children in local authority care. This includes the complexity of problems typically seen amongst this population, making categorization into discrete mental health diagnoses difficult (DeJong, 2010), when contrastingly outcome studies and guidelines are often based on homogenous conditions (Midgley & Kennedy, 2011). Furthermore, there are often practical difficulties with accessing children in local authority care or their foster carers for research purposes, with local authorities acting as informal gatekeepers (Hepstinall, 2000), as well as problems with retaining them to the research (Mezey et al., 2015). Any future RCT study would need to factor in practical considerations concerning recruitment of this population of children into its design, including strategies for accessing and retaining children to the study.

The research undertaken in this thesis became progressively narrower and more focused, culminating in a case study of child psychotherapy in a specialist LAC CAMHS team, within a social care setting. From presenting study 3's findings to a group of 50 child psychotherapists working in a range of settings, several reported that aspects of the study's findings were somewhat different to their own practice. This highlights the necessity of using context-specific, qualitative research studies in developing evidence-based mental health treatments and practice, so that research is clinically meaningful to those working in 'real world' settings. For example, comparing and contrasting study 3's findings with the practice of child psychotherapists working in a generic CAMHS team is a worthy avenue for future research, to establish situational-specific ways of working within these different settings. There is increasing recognition within the literature of the need to include context-specific factors within evidence-based practice (e.g. Barbour & Barbour, 2003), and within child psychotherapy research in particular (Kam & Midgley, 2006), and the research outlined in this thesis supports this view.

A main finding of this thesis is that while child psychotherapy as a profession is typically perceived as providing individual therapy with children, a core component of their work within this field is supporting the professional network, and foster carers. One implication is that further research could be conducted into assessing the impact of psychoanalytic consultation to groups of social workers, or other professionals, working in this field. There is only limited research examining the impact of providing psychoanalytic reflective spaces to social workers, for example O'Sullivan's (2019) doctoral study investigating the impact of a psychoanalytic work discussion group (Rustin & Bradley, 2008) on a group of six child protection social workers. Future research could explore the impact of the specific form of psychoanalytic consultation described in this thesis, to social workers or other professionals working in the children in local authority care field.

6.4 Limitations

This section will discuss overarching limitations of the research; specific limitations of each study have been discussed within the corresponding chapters.

The research undertaken in this thesis was predominantly qualitative in nature, apart from the initial survey of the child psychotherapy profession. Whilst this was an appropriate method for gaining rich, in-depth accounts of child psychotherapists' perspectives of their work with professional networks, it has problems with generalisability of findings outside the settings under study. The research progressively focused down to a single case study of child psychotherapy in a specialist, specific setting. To mitigate effects of the lack of generalisability, a webinar was held to present and discuss the findings with 50 child psychotherapists, working in a range of settings. Future research could consider using multiple case studies to gain a more in-depth understanding of similarities and differences between services, for example comparing child psychotherapy in a specialist LAC service to child psychotherapy in a generic CAMHS team, or in private practice.

The research undertaken in this thesis also predominantly focused on child psychotherapists' perceptions of their work with children in local authority care, and the professional networks around them. The third study triangulated this with researcher observations of their practice, as well as social workers' perceptions about the contribution of child psychotherapy to this field. However again this was only observations and a sample of one social work team working in a specific setting. A finding arising from this series of studies is the widespread perception held by child psychotherapists that there are high levels of conscious and unconscious anxiety within professional networks around children in local authority care, often managed defensively. It is therefore pertinent to explore this perception, and views about the role of child psychotherapy in helping practitioners to manage this anxiety, in greater depth amongst social workers working in different settings. Although study 2 included child psychotherapists' perceptions about their role as consultant to professionals outside of social care, including health and education workers, again the perceptions of these professionals themselves were not included in this research. This is another relevant avenue for future research to explore.

Furthermore, there are elements of child psychotherapists' practice identified as prevalent in study 1 that were not explored in-depth in subsequent studies. For example, work with foster carers was identified as a crucial element of work, and child psychotherapists interviewed in study 2 discussed their role in providing consultation to foster carers. However, in study 3, work with foster carers was not explored in detail, as the local authority did not agree to observations of

consultations with foster carers. Given the emphasis that survey respondents placed on this aspect of practice, it is worthy to explore foster carers' perceptions about their work with child psychotherapists, to identify the unique contribution child psychotherapists can make to working with them. Similarly, the survey questions in study 1 included child psychotherapists' work with adopted children, which was then phased out of subsequent studies. The purpose of this was to narrow the focus of the research; whilst acknowledging that children in local authority care and adopted children likely share some similarities in terms of their experiences – including those of trauma, maltreatment, or loss – there are also different legal systems in place around these children. Moving from foster care to adoption also presents its own challenges and opportunities (Selwyn, 2017). Future research could utilise qualitative studies to gain an in-depth account of child psychotherapists' practice specifically with adopted children; both in terms of their direct therapeutic work, and consultation work with the professional network. This would identify any distinct elements of practice with adopted children compared to practice with children in local authority care.

6.5 Overall conclusions

Historically, it was unclear whether psychoanalytic child psychotherapy with this very vulnerable population, often placed in local authority care due to repeated experiences of trauma, maltreatment and / or neglect, was appropriate due to their complex difficulties. Today, child psychotherapy is used widely with these children in routine clinical practice. Despite this, the findings presented in this thesis propose that child psychotherapists' work with children in local authority care extends far beyond the traditionally perceived role of providing individual therapy. A core feature of the work of child psychotherapists in this field is consultation and reflective practice with the professional network around the child, and work with foster carers. Indeed, these aspects of practice were perceived by child psychotherapists as equally important, and in some cases *more* important, than direct work with the child. However, analysis showed that in many instances these aspects appear to be undervalued by services in comparison to their direct work. This perception may stem from the belief by some service managers and network professionals that child psychotherapy's 'specialism' is providing individual therapy; potentially a wish by

agencies for the therapist to 'fix' the child, and to defend against unbearable feelings of guilt and responsibility inherent in this field of work. For this contribution to be realised, the child psychotherapy profession needs to convince services and commissioners of the value of investing in consultation-based services, with future research needed to assess the impact of psychoanalytic consultation with network professionals and foster carers. Moreover, the challenge for child psychotherapists working in this field is to connect the internal world of the child with the external world of their environment, by keeping the internal world of the child at the forefront of network thinking, and by forming strong working relationships with allied professions such as social care.

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Appendices

Appendix 1. Study 1 ethical approval

UCL RESEARCH ETHICS COMMITTEE
ACADEMIC SERVICES



4 February 2016

Dr Nick Midgley
Research Department of Clinical, Educational & Health Psychology
UCL

Dear Dr Midgeley

Notification of Ethical Approval

Project ID: 8293/001: Psychodynamic psychotherapy for looked after children with histories of maltreatment or abuse

I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee that I have approved your study for the duration of the project until June 2016.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form': <http://ethics.grad.ucl.ac.uk/responsibilities.php>
2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

For non-serious adverse events the Chair or Vice-Chair of the Ethics Committee should again be notified via the Ethics Committee Administrator (ethics@ucl.ac.uk) within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

On completion of the research you must submit a brief report of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

Yours sincerely



Professor John Foreman
Chair of the UCL Research Ethics Committee

Academic Services, 1-19 Torrington Place (9th Floor),
University College London
Tel: +44 (0)20 3108 8216
Email: ethics@ucl.ac.uk
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Appendix 2. Study 1 information sheet and consent form

Psychodynamic psychotherapy with looked after and adopted children: a survey of child psychotherapists

Information Sheet

We are conducting an online survey of child psychotherapists, to explore the ways in which they are currently working with looked after and adopted children. The survey is aimed at all child psychotherapists practising within the UK, even if you are not currently working with looked after and adopted children.

This survey forms part of a PhD project funded by the Association of Child Psychotherapists and University College London, to explore psychodynamic psychotherapy as treatment for looked after children.

We would really appreciate your time in completing the survey, which will provide valuable evidence for how child psychotherapists are working with this highly vulnerable group. We hope that this survey will also raise the profile of the child psychotherapy profession in working with looked after and adopted children.

Your participation is completely voluntary and you may withdraw from the study at any time without penalty. Your answers will remain confidential to myself and my supervisors, and you will remain anonymous in the PhD thesis and any publications. The survey should take around **15 minutes** to complete.

Please complete the survey by [date].

Thank you for your time.

NB. This survey is only aimed at child psychotherapists working in the UK, and does not include those working outside the UK.

Informed consent

- I have read the information sheet above, and understand what the study involves.
- I understand that if I decide at any time that I no longer wish to take part in this project, I can notify the researchers involved and withdraw immediately.
- I consent to the processing of my personal information for the purposes of this research study.
- I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.
- I agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this study.

Do you consent to take part in the study?

- Yes
- No

Appendix 3. Study 1 survey questions

Section 1: Your workplace

We would like to find out about where you work so we can tailor the questions to your circumstances.

1. Where do you work as a child psychotherapist? (tick all that apply)

- Child and Adolescent Mental Health team (Tier 3 CAMHS)
- Hospital-based child and adolescent psychotherapy service
- Early years service
- Court assessment team or service
- School
- Residential or inpatient unit
- Targeted Looked after children team in CAMHS
- Specialist post-adoption service
- LAC team based within social services
- Youth justice service
- Voluntary sector / charity
- Private practice
- Other (please specify)

2. Of the workplace setting(s) that you selected above, in which do you work with, or regarding, looked after and/or adopted children? (tick all that apply)

In this survey, the term 'looked after children' refers to all children and adolescents (under the age of 18) under the care of the local authority, either accommodated with parental agreement or subject to a Care Order. This includes all forms of work with looked after and adopted children i.e. assessment, individual or group psychotherapy, consultation, supervision, teaching, training, research.

- Child and Adolescent Mental Health team (Tier 3 CAMHS)

- Hospital-based child and adolescent psychotherapy service
- Early years service
- Court assessment team or service
- School
- Residential or inpatient unit
- Targeted Looked after children team in CAMHS
- Specialist post-adoption service
- LAC team based within social services
- Youth justice service
- Voluntary sector / charity
- Private practice
- Other (please specify)
- I don't work with looked after and/or adopted children

3. What is the name of the service where you do most work with looked after and adopted children?

4. If you work for a specialist looked after or adoption service, can you describe the remit of your service?

For example, does your service only work with a specific population of looked after and/or adopted children? E.g. those who have just entered care, or those transitioning out of the care system.

We would now like to ask you some questions about the ways in which you work with, or to support, looked after and adopted children.

Section 2: Assessment

1. Which of the following assessments (if any) do you undertake regarding looked after and/or adopted children? (tick all that apply)

- I don't undertake any assessments regarding looked after and/or adopted children

- Assessments concerning the child's suitability for psychotherapy
- Generic assessments as part of a multi-disciplinary team (e.g. at the initial point of referral to CAMHS)
- State of mind assessments
- Other assessments for court (e.g. parenting assessment)
- Other assessment (please specify)

2. If you have any comments about the assessment work that you do regarding looked after and/or adopted children, please provide them here.

Section 3: Direct psychotherapy with looked after and adopted children

1. Do you provide direct psychotherapy to looked after and/or adopted children?

i.e. meet with the child in person to undertake psychotherapy.

- Yes
- No

(If no they would move on to the next section)

2. Please estimate the percentage of children making up your current caseload of psychotherapy cases that are looked after or adopted.

3. What is the age range of looked after and/or adopted children that you work with? (tick all that apply)

- 0-5 years
- 6-10 years
- 11-15 years
- 16 years and above

• What are the most frequent presenting problems of looked after and/or adopted children that you see in psychotherapy? (please choose a maximum of 5 options)

- Anxiety disorders
- Depression
- Conduct disorders / behavioural problems
- Risk of school exclusion
- Risk of foster/adoption placement breakdown
- Attachment related problems
- Impact of maltreatment / trauma
- Learning disabilities
- Autistic spectrum disorders
- Hyperkinetic disorders
- Self-harm / suicide attempts
- Eating disorders
- Offending behaviour
- Sexualised behaviour
- Previous treatments have been unsuccessful
- Other reason

If you have any comments about the reasons that looked after and adopted children are referred for psychotherapy, please provide them here.

4. Who do you work with when offering psychotherapy to looked after and/or adopted children? (tick all that apply)

- I work individually with the child
- I work with children in a group
- I work with the child together with foster parents, adoptive parents, and/or birth family
- Other (please specify)

5. Which of the following types of work do you offer with looked after and/or adopted children? (tick all that apply)

- Brief psychotherapy (usually 1-6 sessions)
- Short-term psychotherapy (usually 7-30 sessions)
- Open ended psychotherapy, usually less than 1 year
- Open ended psychotherapy, usually more than 1 year

6. **What is the frequency of the psychotherapy sessions you offer with looked after and/or adopted children? (tick all that apply)**
- Less than once a week
 - Once a week
 - More than once a week
7. **If you have any other comments / information you would like to provide about your direct therapeutic work with looked after and/or adopted children, please provide them here.**

Section 4: Work with foster or adoptive carers / families

1. **Which of the following types of work (if any) do you undertake with foster and/or adoptive carers/families? (tick all that apply)**
- I don't do any work with foster or adoptive carers/families
 - Consultation
 - Training
 - Direct work with foster carers or adoptive parents alongside individual psychotherapy with the child
 - Direct work with foster carers or adoptive parents, which is not alongside individual psychotherapy with the child
 - Direct work with foster carers or adoptive parents in groups
 - Other (please specify)

1. **If you have any further comments or details about the work that you do with foster and/or adoptive carers/families below, please provide them here.**

Section 5: Consultation

1. **What consultation work do you do with professionals regarding looked after and/or adopted children?**

This includes commissioned consultancy work as well as more informal consultation.

- I don't do any consultation work regarding looked after and/or adopted children
- Consultation with social care professionals
- Consultation with trainee or qualified child psychotherapists
- Consultation with other mental health professionals
- Consultation with education professionals / early years services
- Consultation with other professionals (please specify)

2. What is the nature of the consultation that you provide?

Please include any other comments about the consultation work you do as well.

Section 6: Supervision

1. Which of the following groups (if any) do you provide supervision for regarding looked after and/or adopted children? (tick all that apply)

- I don't provide any supervision regarding looked after and/or adopted children
- Child psychotherapists
- Social care professionals
- Other mental health professionals
- Education professionals / early years services
- Foster carers
- Other (please specify)

Section 7: Teaching / training

1. Which of the following groups (if any) do you provide teaching / training for regarding looked after and/or adopted children? (tick all that apply)

- I don't provide any teaching/training regarding looked after and/or adopted children
- Trainee child psychotherapists
- Qualified child psychotherapists
- Other child mental health professionals
- Social care professionals
- Education professionals / early years services
- Foster carers or adoptive parents
- Other (please specify)

2. What is the focus or nature of the teaching / training that you provide?

Please include any other comments about the teaching / training work you do as well.

Section 8: Research & evaluation

1. Do you undertake any research or evaluation regarding looked after and/or adopted children?

- Yes
- No

2. What is the focus or nature of your research and/or evaluation regarding looked after and/or adopted children?

3. What kind of evaluation methods (if any) do you/your service use to evaluate your work with looked after and/or adopted children? (tick all that apply)

- I don't use any evaluation methods
- Routine outcome monitoring measures
- Qualitative feedback
- Service audit
- Other type of research evaluation
- Don't know

- Other (please specify)
3. **If you have published any research or evaluation regarding looked after and/or adopted children, and would like to provide details of this, please do so here.**

Section 9

1. **What do you consider the unique contribution that child psychotherapists make to work with looked after and/or adopted children?**

For looked after and/or adopted children who are offered psychoanalytic therapy, please say briefly why you think this approach is chosen and/or what it uniquely offers.

Section 10: About you

1. **Where in the UK are you situated?**
- London
 - South England (S. East and S. West)
 - East of England
 - Midlands
 - North England
 - Yorkshire and the Humber
 - Wales
 - Scotland
 - N. Ireland
2. **What is your gender?**
- Female
 - Male
3. **Are you a trainee child psychotherapist, or a qualified child psychotherapist?**
- Trainee child psychotherapist

- Qualified child psychotherapist

If qualified, how many years has it been since you qualified as a child psychotherapist?

4. **Where did you train / are currently training as a child psychotherapist?**

- Anna Freud Centre
- Birmingham Trust for Psychoanalytic Psychotherapy
- British Psychotherapy Foundation (previously BAP)
- Human Development Scotland
- Lowenfeld/IPC
- Northern School of Child and Adolescent Psychotherapy
- Tavistock and Portman NHS Foundation Trust

5. **Did you work with looked after and/or adopted children in any capacity prior to your training as a child psychotherapist?**

- Yes
- No

If yes, in what context was this?

For the next phase of the PhD project, we are looking to conduct interviews with a sample of child psychotherapists, to gain an in-depth understanding of the work that is being done with looked after and/or adopted children. If you are happy to be contacted about the next phase of the study, or might be interested to be involved in later stages of the study in some way, please provide your **name** and **email address** below. These details will remain confidential to myself and my supervisors and will not be used in the PhD thesis or any publications.

Name...

Email address...

Thank you for your time in completing the survey. We hope it will provide valuable evidence regarding the ways in which child psychotherapists are working with looked after and adopted children in the UK. The survey forms the first phase of the PhD

project, and we will aim to report on the findings in the ACP Bulletin and/or on the member's section of the ACP website.

If you would like to contact us for further information about the study, you can do so using the contact details below:

Fiona Robinson

PhD student (funded by UCL and the ACP)

fiona.robinson@annafreud.org

Nick Midgley (PhD supervisor)

Child and Adolescent Psychotherapist at the Anna Freud Centre, and Lecturer at UCL Department of Clinical, Educational and Health Psychology

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Appendix 4. Feedback received from piloting and changes made to survey questions for Study 1

Feedback received from piloting	Amendments to survey
<p><i>Survey length</i> – overall, the feedback suggested the length of the survey was fine. However, some of the questions were perceived as quite repetitive.</p>	<p>Some questions were combined to make the survey shorter and more concise.</p>
<p><i>Clarity of questions</i> – one participant was unclear whether the term ‘consultation’ referred to commissioned consultations and/or informal consultations.</p>	<p>A definition of consultation was included, to encompass both commissioned and informal work.</p>
<p><i>Appropriateness and inclusiveness of response options</i> – the response options for ‘presenting problems of looked after and adopted children in child psychotherapy’ and ‘types of work conducted with foster carers’ were not perceived to be fully inclusive.</p>	<p>Additional response options were incorporated based on the participants’ suggestions.</p>
<p><i>Survey structure</i> – there was too much emphasis on direct work with looked after and adopted children, rather than work with the professional network e.g. assessment and consultation, which the participant felt were vital interventions with these children.</p>	<p>The survey structure was altered so that each type of work had its own section. The flow of questions was altered to reflect the ‘flow’ of a child psychotherapists’ potential work i.e. starting with assessment and ending with service evaluation.</p>

Appendix 5. Themes/sub-themes developed from the Study 1 qualitative data

Direct psychotherapy with looked after and adopted children

Sub-themes	Definition	Example quotations
Uniqueness of the therapeutic relationship	<p>Discussion about the uniqueness of the therapeutic relationship e.g.</p> <ul style="list-style-type: none"> • Depth of relationship • Use of transference and counter-transference • The focus of the therapeutic relationship e.g. understanding the internal world • Relational approach • Long-term work needed – intensity of intervention, able to / should give the time and space needed 	<p>“It offers for the child a consistent therapeutic relationship with an opportunity to begin to internalise a more benign and trustworthy adult.”</p> <p>“A relationship, outside the home, which is private, and which can develop and change over time, within which to explore their experiences and feelings at their own pace.”</p> <p>“I think it offers them a unique opportunity to really work through their very difficult past circumstances, have a chance to develop in the context of a long term, safe, trustful relationship. This cannot be easily done in short-term work.”</p>

The therapeutic setting	Description of the therapeutic setting and sessions e.g. safe space, reliable, stability	“I think it offers them a reliable and predictable space...”
		“These children are often traumatised and destructive, they respond to the boundaried way we work (ie same room, same time etc).”
Characteristics of the therapist	<p>For example:</p> <ul style="list-style-type: none"> • Non-judgmental • Flexible / adaptive approach • Capacity to engage these children - when other professionals struggle to • Commitment / consistency • Understanding of child development • Able to tolerate / bear projections • The therapists’ own training and personal analysis 	“It offers the child an adult who can tolerate their extreme behaviours and accept their powerful projections.”
		“Often seen as only clinicians who can engage such patients.”
		“Importance of being able to stick with the child through the difficult times, and modification of technique.”
		“Analysis helps develop resilience in the therapist

		and helps sustain during this difficult work.”
Impact of psychotherapy on looked after and adopted children	What child psychotherapy offers these children and how it can impact on them, for example building resilience, helping them to distinguish reality from fantasy	<p>“When it works, it uniquely offers the possibility to a child/young person of coming to a better understanding of the traumatic impact of their experiences on their current relationships and view of the world.”</p> <p>“It is a treatment that brings about internal changes and not just a reduction in symptoms.”</p>
Occasions when psychotherapy is unsuitable for looked after and adopted children	Occasions when psychotherapy in general, or forms of psychotherapy, might not help or be appropriate for these children e.g. those in unstable placements	<p>“I don’t always find individual psychotherapy helpful with some of these children. There is a real need to better understanding their functioning and their way of communicating.”</p> <p>“Brief psychotherapy tends to be unsuitable for children that have experienced trauma and or</p>

		abuse and that might still be living in very uncertain circumstances at the time of referral, for example unstable placements or court proceedings.”
Specific initiatives / models of working	Description of specific initiatives that child psychotherapists are using e.g. Theraplay	“I have recently been working with colleagues undertaking joint work using the under 5's Tavistock model of working with the adoptive/fostered child and the family in an attempt to offer a sense of a parental thinking couple.”

Perceptions about looked after and adopted children / the care system

Definition	Example quotations
<ul style="list-style-type: none"> Presenting problems of these children in psychotherapy e.g. attachment / trauma related issues Complexity of difficulties Perceptions about the families who are seen in psychotherapy e.g. 	<p>“Usually, the pathology is very deep: not only are they in care because of neglect or abuse, but they are doubly damaged by being taken into care.”</p> <p>“It is difficult and painful for child and psychotherapist. It can evoke anger, outrage</p>

	<p>mistrustful of professionals</p> <ul style="list-style-type: none"> • Child psychotherapists' thoughts about the care system • Child psychotherapists' feelings about therapy with these children e.g. beneficial but complex work 	<p>and upset for the psychotherapist...for the child, it can be heart-breaking to let go of psychological defences that once seemed effective and become aware of what they have missed out on in their birth family...that is what makes the work so hard.”</p> <p>“Child psychotherapists should be realistic about how much progress is possible and at same time be prepared for a long engagement with some children as it can take at least three years of work to get to the heart of a child in care.”</p>
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Assessment

Sub-themes	Definition	Example quotations
Nature of assessment work	<ul style="list-style-type: none"> • Purpose / remit of work • Who requests assessments e.g. social care • Models of working 	“Most assessments involve an initial period of discussions/consultation with the network, followed by assessment sessions with

	<ul style="list-style-type: none"> • Diversity of approaches to this work – flexible approach needed. 	<p>the carers/parents, then family/child.”</p>
		<p>“Referring Social Care teams always want assessments for suitability for individual psychotherapy.”</p>
<p>Views / perceptions of assessment work</p>	<ul style="list-style-type: none"> • Importance of this work • Complexity of work • Difficulties of conducting assessments e.g. access to information from social care, organisational constraints. • Other professionals’ views of child psychotherapists assessments (as perceived by respondents) 	<p>“Assessments are an invaluable part of my work in CAMHS, for patient, carers and my own work also as an intervention in itself.”</p> <p>“Often the assessment information is needed in a tight time frame and this places a lot of pressure on an already busy CAMHS team. The quality of the early assessments on children when they are taken into Care do not focus enough on the child's needs and therefore can give an over optimistic view on what can be managed or support needed once the children are placed in adopted or foster placements.”</p>

Working with the network during assessments	<ul style="list-style-type: none"> • Role of the professional network in child psychotherapy assessments. • Joint working / multi-disciplinary approach to assessment. 	<p>“Often requires a more lengthy piece of work with the network prior to any assessment.”</p> <p>“Reports are disseminated through the social care database with the aim of informing care planning and LAC reviews. We work closely with the children in care health team who carry out statutory health assessments and reviews and have produced guidance in collaboration with nurses.”</p>
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Working with the professional network

This theme mainly comprises consultation work but there is also some overlap with other types of work e.g. assessment. This theme does not include work with foster carers and adoptive parents

Sub-themes	Definition	Example quotations
Nature of work with the professional network	<ul style="list-style-type: none"> • Who child psychotherapists are consulting with, where they consult (schools, social care etc) • Nature of work with the professional network e.g. 	<p>“The focus would be on helping those working directly with the young person to better understand their puzzling or unsettling behaviours or presentations, using a</p>

	<p>group versus individual consultation, informal versus commissioned consultation, prep work with the network before individual psychotherapy can begin.</p> <ul style="list-style-type: none"> • Focus / purpose of work with the professional network e.g. help professionals to better understand the child's behaviour, encouraging reflective practice. • Diversity of approaches to this work – flexibility needed. 	<p>psychoanalytic perspective.”</p> <p>“Consultation to social workers as part of a rota for the LAC team. For any potential referral to our team, this is initially discussed with our team in terms of suitability and also begins the process of linking together in thinking about the child and family.”</p>
<p>Views / perceptions of working with the professional network</p>	<ul style="list-style-type: none"> • Emphasis / importance placed on this work • Network dynamics. • Managing professionals' anxieties. • Difficulties of working with the network • Other professionals' views of child psychotherapy (as perceived by respondents) 	<p>“Often there are frequent changes to this network and working out the child's/ young person's relationship in the external world needs to run parallel to work to understand their internal world. This distinguishes the work from CPT with children who live in birth families.”</p>

“The networks around looked after children often get caught up in difficult dynamics, and child psychotherapists are well placed to be able to help address such dynamics and make the network more thoughtful about the child's needs.”

“Carers and social workers appreciate the understanding the therapist brings to the child's presentation.”

Working with foster carers and adoptive parents

Sub-themes	Definition	Example quotations
Nature of work with foster carers / adoptive parents	<ul style="list-style-type: none"> • Purpose / focus of work with families e.g. strengthen bond between child and carer, enable carer to better understand the child, thinking about the impact of the work on carers • Ways of working with foster carers e.g. group work, jointly with carer and child, individual work with carer • Diversity of approaches to this work – the need to be flexible according to each families' need 	<p>“I use varied approaches according to need, work with parents as a couple, with their adopted child or in a family context, or in parenting groups with parenting course.”</p> <p>“...helping them understand what the child is communicating through their behaviour, and thinking about the emotional impact of being with a traumatised child.”</p>
Views / perceptions of working with foster carers and adoptive parents	<ul style="list-style-type: none"> • Emphasis on the importance of this work • Organisational issues for this work e.g. lack of support / training for foster carers (also can be coded under organisational constraints code) 	<p>“Their work is desperately important and yet the carers rarely have sufficient training or support to understand these doubly-damaged children and young people.”</p>

<ul style="list-style-type: none"> • Difficulties that foster carers may experience in caring for these children • Foster carers' feelings about child psychotherapy (as perceived by respondents) • Child psychotherapists' feelings about working with foster carers and adoptive parents 	<p>“This can be very painful and complex work and good supervision is important.”</p> <p>“Sometimes the treatment of choice where resources are limited would be to work with the carers to help the better understand their fostered or adopted child and this to help strengthen their (often fragile) bond.”</p>
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Organisational constraints

Definition	Example quotations
<ul style="list-style-type: none"> • Resource / financial constraints / other pressures • Organisational changes e.g. within CAMHS • Difficulties accessing services, waiting lists etc • Service remit limitations e.g. emphasis on short-term interventions 	<p>“CAMHS LAAC teams are struggling with the volume and complexity of problems that are presented, at a time of unprecedented cuts in services. Most CAMHS teams are struggling to meet the needs of this highly vulnerable population of children.”</p>

-
- | | |
|---|---|
| <ul style="list-style-type: none"> Difficulties accessing information on these children e.g. from social care. | <p>“I would want to be able to offer a more substantial intervention to LAC children in my CAMHS ie longer term work, higher frequency of sessions, parallel parent support work etc. However the CAMHS only supports short term minimal Psychotherapeutic interventions. What I am able to do I feel is minimal and inadequate.”</p> <p>“Only LAC presenting with severe and enduring mental health problems receive a service. Many other vulnerable LAC are not eligible to receive help.”</p> |
|---|---|
-

Comparing / contrasting child psychotherapy to other treatments

Definition	Example quotations
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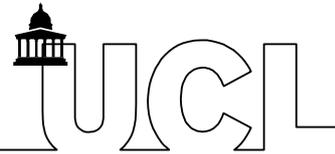
- | | |
|---|--|
| <ul style="list-style-type: none"> Differences between child psychotherapy and other interventions e.g. CBT / short-term interventions | <p>“Despite other treatment methodologies being robust e.g. CBT are well researched they are often unable to provide an emotional connection</p> |
|---|--|
-

-
- Views of psychotherapy as a specialist approach or a “last resort” option when other treatments have failed e.g. too expensive. to allow the child to process their traumatic experiences and develop the beginning of a trusting relationship with an adult.”
 - Perceived tension between child psychotherapy and more ‘outcome-focused’ / evidence-based treatments. “It offers an intensity of intervention unequalled by other interventions when combined with foster carer/parent support + professionals meetings + reviews.”
 - Difficulties of getting certain types of work commissioned compared to other treatments. “Last resort when other approaches haven't helped.”
- “I understand that EDMR now purports to working with developmental trauma and I am concerned that the use of psychotherapy for this is not dismissed as being too expensive or too long term in preference for other
-

models such as EDMR
or Trauma CBT.”

Appendix 6. Study 2 ethical approval

**UCL RESEARCH ETHICS COMMITTEE
ACADEMIC SERVICES**



15 August 2016

Dr Nick Midgley

Research Department of Clinical, Educational and Health Psychology
UCL

Dear Dr Midgley

Notification of Ethical Approval

**Re: Ethics Application 8293/002: Psychodynamic models of working with
looked after children with histories of trauma or maltreatment**

I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee that I have ethically approved your study until 15 August 2017.

Approval is subject to the following conditions.

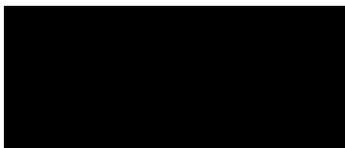
1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form':
<http://ethics.grad.ucl.ac.uk/responsibilities.php>

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

For non-serious adverse events the Chair or Vice-Chair of the Ethics Committee should again be notified via the Ethics Committee Administrator (ethics@ucl.ac.uk) within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

On completion of the research you must submit a brief report of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

Yours sincerely



Professor John Foreman

Chair of the UCL Research Ethics Committee

Cc. Ms Fiona Robinson, Applicant

Appendix 7. Study 2 participant information sheet

LONDON'S GLOBAL UNIVERSITY



UCL

Title of project: Psychodynamic models of working with looked after children with histories of trauma or maltreatment

This study has been approved by the UCL Research Ethics Committee: Project ID Number 8293/002

What is this study about?

We would like to invite you to participate in this study, which is exploring the ways in which child psychotherapists are currently working with the professional network around looked after children, including work with foster carers. This study forms part of a PhD project funded by University College London and the Association of Child Psychotherapists, to investigate psychodynamic models of working with looked after children.

What does participation involve?

If you agree to participate in the study, you will be asked to meet the researcher for an interview. The interview can be conducted either in person, via Skype or on the telephone depending on which is most convenient and preferable. The interview will last around an hour in length (maximum 90 minutes) and will be digitally recorded. During the interview, you will be asked questions about the ways in which you work with the professional network around looked after children; in what ways you feel that this work has been effective or successful; and what you see as the obstacles to undertaking this work. You will not be asked to provide any information that could

identify specific carers or children under their care, or contravene your professional confidentiality and data protection procedures. Your participation is completely voluntary and you may withdraw from the study at any time without penalty.

What are the benefits of taking part?

We hope that the study will provide valuable practice-based evidence for how child psychotherapy is being utilized with the professional network around looked after children. You may also find it interesting to reflect on this aspect of your work.

What will happen to the study data?

Your data will be treated as confidential. The interviews will be transcribed by the researcher; this will include anonymising any personal or identifying details. Data will be held securely on a password protected computer and in accordance with the Data Protection Act (1998). Only the researchers involved in the study (see contact details below) will access your data. The data will be retained for the duration of the PhD and then disposed of in a secure manner. Findings from the study will be written up for the PhD thesis, and possibly for publication in academic journals and for presentation at conferences. Although direct quotes may be used, these will be anonymised.

Contact information

Fiona Robinson
PhD student, UCL and the Anna Freud Centre
fiona.robinson@annafreud.org

Nick Midgley (PhD supervisor)
Child and Adolescent Psychotherapist at the Anna Freud Centre, and Lecturer at
UCL Department of Clinical, Educational and Health Psychology
Nick.MidgleyPhD@annafreud.org

Patrick Luyten (PhD supervisor)

Reader at the Research Department of Clinical, Educational, and Health Psychology
at UCL

p.luyten@ucl.ac.uk

Appendix 8. Study 2 consent form



Consent form

Title of project: Psychodynamic models of working with looked after children with histories of trauma or maltreatment

Name:

- I have read the notes in the information sheet, and understand what the study involves.
- I understand that if I decide at any time that I no longer wish to take part in this project, I can notify the researchers involved and withdraw immediately.
- I consent to the processing of my personal information for the purposes of this research study.
- I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.
- I agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this study.

Signed:

Date:

Appendix 9. Study 2 interview schedule/topic guide

Name of service(s) worked for:

Type of service(s) (CAMHS etc):

Location of service(s):

Remit of service(s):

1. Main problems/needs of the professional network that they can help with as a child psychotherapist

Probe: Child's needs versus needs of the network itself.

2. Description of their work with the professional network

Probes:

- Direct therapeutic work? Consultation? Training?
- Format of work - group / individual / couple?
- Number of sessions? Frequency?
- Content / focus of sessions.
- Essential versus "elective" content areas?
- How structured are the sessions?
- Who sets the agenda for sessions – therapist or collaboratively?
- Skills used

3. What difference do they think this work has made to a) the network and b) the child?

Probes:

- Factors or processes that are associated with change or improvement
- Feedback from professionals / foster carers

- Why do you do this work with professionals / foster carers specifically? (rather than just focusing on the child)
- Evaluation? Outcome measures?

4. How is this approach different from the ways that other professionals work with the professional network/ foster carers?

Probes:

- What do you, as a child psychotherapist, uniquely offer?
- Is this approach different to approaches you were taught during your training?
- Similarities / differences to ways of working with other children

5. Any challenges to working with the professional network in this way

Probes:

- Organisational obstacles e.g. resource constraints
- Difficulties that emerge during direct work with foster carers?

6. Any other aspects of working with the professional network / foster carers?

Probes:

- Similarities and differences in working with professionals versus foster carers?

Appendix 10. Example of thematic analysis process used in study 2

Braun and Clarke's (2006) approach to thematic analysis was used. According to this approach, there are six stages to conducting a thematic analysis, namely: familiarising yourself with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; producing the report. However, during this process, the researcher is often going back and forth between the different stages during the analytic process.

I will illustrate an example of how the thematic analysis was conducted during study 2.

1. Familiarising yourself with the data

Braun and Clarke (2006) state that this stage involves repeatedly reading the data in an active way, for example, looking for patterns occurring across the data. From this active reading, the researcher should then be able to produce a list of ideas about what the data comprises. During this stage I read through my interview transcripts several times, noting down in the margins things that struck me as interesting, or what I thought participants were talking about and what was going on in the data.

2. Generating initial codes

This stage involves organising the data into codes, comprising interesting features of the data. Codes are at a more basic level than themes, which are much broader and involve a level of interpretation. By the end of this stage, the researcher should have a list of the different codes arising from the data.

During this stage, I coded my interview transcripts in Nvivo 11, a qualitative data analysis software package which allows researchers to highlight passage of text and assign codes to them. As an example, the extract below was coded under the following codes: 'organisational constraints', 'providing psychoanalytic understanding to networks', 'thinking space', and 'networks losing sight of the child':

I mean the first thing that I think is profoundly noticeable is how under-resourced local authorities are. And I think with being under-resourced and the pressure they're under, my take on child psychotherapy or

psychoanalysis, is about thinking. Thinking about what's conscious and what's unconscious. Local authorities don't have I think, don't really have a significant amount of time to think about the needs of the children. So I think there's a tendency to be very reactive in terms of how they think about the needs of the child, and I mean it's very reactive rather than being a proactive, thinking in advance where a child is, where a foster carer is (P6).

All of the text in the interview transcripts were coded in this way, until I had a long list of codes in Nvivo.

3. *Searching for themes*

This stage involves drawing out themes from the initial codes, which occurs through analysis of the codes i.e. looking at how codes might combine to make an overarching theme, often which contain sub-themes. During this stage, the relevant coded data is organised under each theme. Below is an example of how my initial codes were collated into sub-themes, and a main theme (which was later renamed).

Initial codes	Sub-themes	Theme
<ul style="list-style-type: none"> • Child psychotherapist acting as the 'voice' of the child 	<ul style="list-style-type: none"> • Helping networks to understand the child's behaviours and communications 	<ul style="list-style-type: none"> • Creating a thinking space in networks
<ul style="list-style-type: none"> • Networks losing sight of the child 	<ul style="list-style-type: none"> • Thinking about network functioning and anxiety 	
<ul style="list-style-type: none"> • Providing a psychoanalytic understanding of the child's behaviour 	<ul style="list-style-type: none"> • Working with networks rather than providing direct therapy to the child 	
<ul style="list-style-type: none"> • Addressing blame, splits, conflicts in the network 		
<ul style="list-style-type: none"> • High levels of network anxiety 		

By the end of this stage, I had organised all my codes into themes and sub-themes in Nvivo 11.

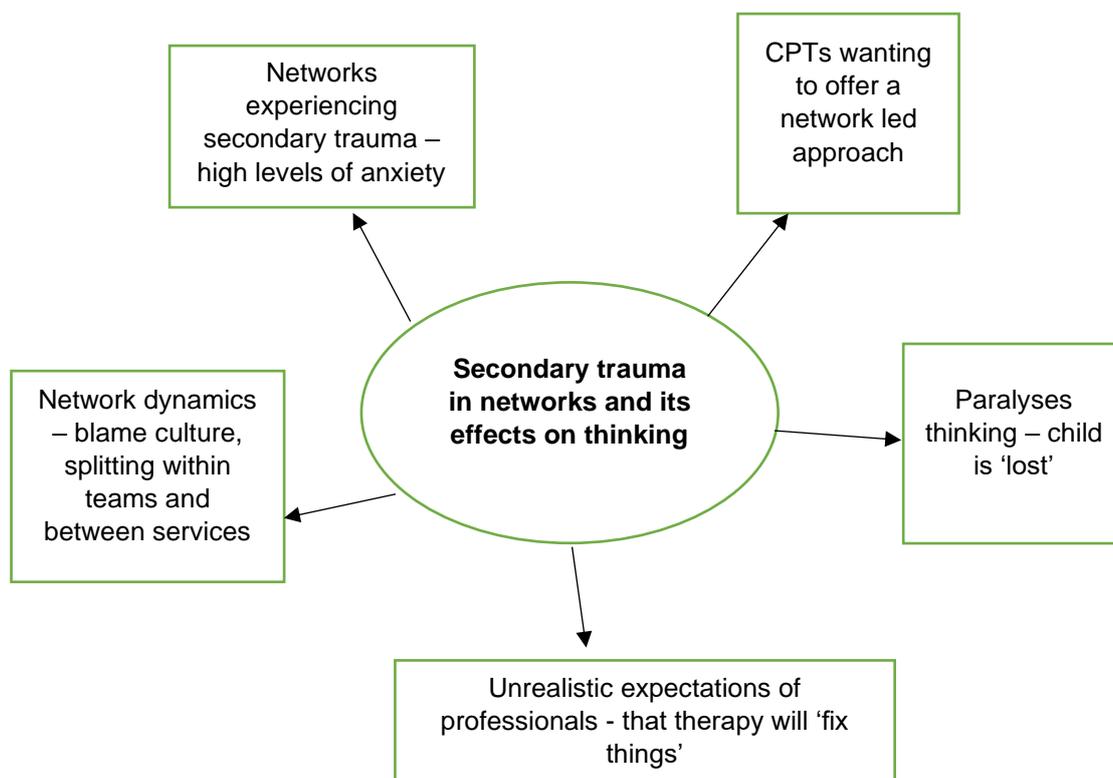
4. *Reviewing themes*

This stage involves reviewing the identified themes to assess whether they are working – for example, some themes might end up collapsing into each other, or it becomes apparent that a theme does not contain enough data extracts. By the end of this stage, the researcher should be clear that the themes all complement each other but are also distinct from each other.

During this stage I organised my themes and sub-themes into thematic maps, as advised by Braun and Clarke (2006). An example of one of my thematic maps can be seen in Figure 4.

Figure 4

Example of thematic map



I presented my initial themes to my supervisors, along with two interview transcripts so they could review the development of themes. At this stage, I had three main themes, namely: 'secondary trauma in networks and its effects on thinking'; 'networks lack a "thinking space"'; and 'creating a thinking space in networks'. However, upon discussion with my supervisors, we agreed that I could take a more interpretative stance to my analysis, emphasising the narrative that child psychotherapists experienced various tensions within their role as consultant to the professional network. We discussed refinements to the themes and sub-themes until mutual agreement was reached. Once I had refined my themes, I read back through all the interview data to ensure they accurately represented what was being said in the data and reflected the narrative I wanted to tell about child psychotherapists' work with the professional network around children looked after.

5. Defining and naming themes

This stage involves naming each theme, and describing what it includes, and also what it does not include. During this stage I wrote a description of the contents of each theme and sub-theme, as well as instances of what should not be contained under each theme. The names of my themes and sub-themes were refined from previous stages, for example 'secondary trauma and its effects on thinking' was renamed 'the tension between the networks' wishes and what child psychotherapists feel they can offer', as I felt this more accurately reflected the dataset.

6. Producing the report

This stage involves the final write-up of the analysis and report. Whilst writing up the analysis, I considered the narrative I wanted to tell, and attempted to provide a logical, coherent argument for this narrative, including example quotations for each theme and sub-theme.

Appendix 11. Study 3 UCL ethical approval

UCL RESEARCH ETHICS COMMITTEE
ACADEMIC SERVICES



16th May 2017

Dr Nick Midgley
Research Department of Clinical, Educational and Health Psychology
UCL

Dear Dr Midgley

Notification of Ethical Approval

Re: Ethics Application 8293/003: Psychodynamic models of working with looked after children with histories of trauma or maltreatment

I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee that I have ethically approved your study until **16th May 2018**.

Approval is subject to the following conditions:

Notification of Amendments to the Research

You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form':

<http://ethics.grad.ucl.ac.uk/responsibilities.php>

Adverse Event Reporting – Serious and Non-Serious

It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Chair or Vice-Chair of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

Academic Services, 1-19 Torrington Place (9th Floor),
University College London
Tel: +44 (0)20 3108 8216
Email: ethics@ucl.ac.uk
<http://ethics.grad.ucl.ac.uk/>

Appendix 12. Study 3 NHS HRA approval



Dr. Nick Midgley
 Research Department of Clinical, Educational and Health
 Psychology
 University College London
 Gower Street
 WC1E 6BT

Email: hra.approval@nhs.net

07 July 2017

Dear Dr Midgley

Letter of HRA Approval

Study title:	Psychodynamic models of intervention for looked after children with histories of maltreatment or trauma
IRAS project ID:	227718
REC reference:	18/HRA/0085
Sponsor	University College London

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

IRAS project ID	227718
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It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document "*After HRA Approval – guidance for sponsors and investigators*" gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>.

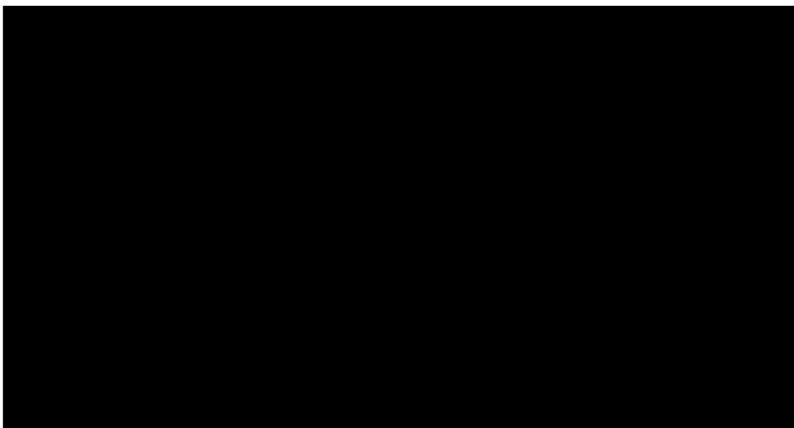
HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

IRAS project ID	227718
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Your IRAS project ID is **227718**. Please quote this on all correspondence.

Yours sincerely



Appendix 13. Study 3 confirmation of capacity and capability from local participating NHS Trust

RE: IRAS 227718. Confirmation of Capacity and Capability at [name of NHS Foundation Trust removed]

Full Study Title: Psychodynamic models of intervention for looked after children with histories of maltreatment of trauma.

Latest HRA Approval Date: 07/07/2017

Site PI/LC: NAMES REMOVED

This email confirms that [name of London NHS Foundation Trust] has the capacity and capability to deliver the above referenced study. Please find attached the agreed Statement of Activities as confirmation.

[Name of NHS Foundation Trust] agrees to start this study on a date to be agreed when you as sponsor give the green light to begin. Please ensure the R&D office and local CRN contacts are provided with this date.

If you wish to discuss further, please do not hesitate to contact us.

As specified in the HRA Approval, Letters of Access for the research team are not considered necessary.

Please note, in line with national HRA approvals process, you will no longer receive an NHS R&D Approval/Permission letter.

Kind regards

[NAME REMOVED]

On behalf of [Name of NHS Foundation Trust]

Appendix 14. Study 3 participant information sheets

LONDON'S GLOBAL UNIVERSITY



Information sheet – child psychotherapists in the [Name of LAC CAMHS]

Title of project: Psychodynamic models of intervention for looked after children with histories of trauma or maltreatment

This study has been approved by the UCL Research Ethics Committee: Project ID Number 8293/003

What is this study about and why is the research taking place?

We would like to invite you to participate in this study, which is exploring the child psychotherapy service in the [name of LAC CAMHS]. This study forms part of a PhD project funded by University College London and the Association of Child Psychotherapists, to investigate psychodynamic models of working with looked after children (LAC). The overarching aim is to understand the role and contribution child psychotherapists can make to working in a multi-disciplinary CAMHS team in a LAC social care setting, from the perspectives of child psychotherapists, other mental health clinicians, and social care professionals.

What does participation involve?

If you agree to participate in the study, you will be asked to participate in several methods of data collection:

- The researcher would like to observe the services you provide to LAC professionals. This would comprise the researcher observing your formal and informal consultations with professionals working with LAC, and making

detailed notes on those observations. During the observation period, the researcher will sit alongside you in the office and observe your practice at your desk and whilst you conduct any planned or more informal consultations with social workers, such as conversations in the corridors or across desks. No confidential details will be included in the researcher's notes, but you can ask me to pause my observation at any point, if necessary.

- Furthermore, the researcher would like to attend your weekly CAMHS team meetings during the observation period, again making observation notes on this. During the consultation sessions, the researcher will be sitting quietly taking notes. The focus of the observations will be on the services you provide to professionals working with looked after children, for example the structure and format of consultations, interactions between yourselves and professionals, and possible changes occurring as a result of the consultations. The researcher will also be observing what distinguishes your role within multi-disciplinary consultation, and how the consultation service you provide fits within a social care context. No observations of therapy sessions with children will take place.
- Following each observation, the researcher may like to briefly interview you, to discuss what was observed. These interviews will last no more than 15 minutes and will be digitally recorded.
- You will be asked to meet the researcher for an interview(s). The interview will last around 60-90 minutes in length and will be digitally recorded. During the interview, you will be asked some questions about the services you provide to families and professionals working with LAC, and what you think is the contribution that child psychotherapy can make to a LAC social care team.

What are the benefits of taking part?

We hope that the study will provide valuable practice-based evidence for how child psychotherapy is being utilized in a CAMHS team embedded within social care. This study will provide understanding of the child psychotherapists' role in a specialist LAC setting to both the wider child psychotherapy and social care professions.

You may also find it interesting to reflect on your work.

What are the potential disadvantages of taking part?

As taking part in the research will involve meeting the researcher for interviews, this will obviously have a minor inconvenience on your time.

What will happen to the study data?

Your data will be treated as confidential. The interviews will be transcribed by the researcher; this will include anonymising any personal or identifying details. You will not be asked to provide any personal or identifying details of the families that the service works with, and no details of families will be recorded in the observation notes. Your details will be anonymised in the observation notes. The only occasion in which confidentiality will be breached is if there are any disclosures of harm or malpractice, or potential harm or malpractice, which will be discussed with your supervisor.

Data will be held securely on a password protected computer and in accordance with the Data Protection Act (2018). Only the researchers involved in the study will access your data. The data will be retained for the duration of the PhD and then disposed of in a secure manner. Findings from the study will be written up for the PhD thesis, and possibly for publication in academic journals and for presentation at conferences. Although direct quotes may be used, these will be anonymised. With your permission, we would like to retain your contact details after data collection has ended, so that we can contact you for feedback on the study findings prior to publication. Your contact details will be kept securely on a password protected computer and in accordance with the Data Protection Act (2018). We anticipate that you will be re-contacted about the study findings in early 2020.

If at any time you no longer wish to take part in the study, you can notify the researchers and withdraw immediately with no penalty.

Privacy statement

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice: <https://www.ucl.ac.uk/legal-services/privacy/ucl-general-research-participant-privacy-notice>

UCL is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. UCL will keep identifiable information about you for the duration of the PhD research. The lawful basis that would be used to process your personal data will be performance of a task in the public interest.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

The PhD researcher will collect information from you for this research study in accordance with our instructions. The researcher will keep your name and contact details confidential and will not pass this information to UCL. The researcher will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from UCL and regulatory organisations may look at your research records to check the accuracy of the research study. UCL will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details. The researcher will keep identifiable information about you from this study until the PhD research is complete.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Contact information

Fiona Robinson

PhD student, UCL and the Anna Freud Centre

fiona.robinson.15@ucl.ac.uk

Nick Midgley (PhD supervisor)

Associate Professor at UCL, and co-director of the Child Attachment and Psychological Therapies Research Unit (ChAPTRe), at UCL / the Anna Freud National Centre for Children and Families.

Nick.MidgleyPhD@annafreud.org

Patrick Luyten (PhD supervisor)

Reader at the Research Department of Clinical, Educational, and Health Psychology at UCL

p.luyten@ucl.ac.uk



Information sheet – other professionals in the [Name of LAC CAMHS]

Title of project: Psychodynamic models of intervention for looked after children with histories of trauma or maltreatment

This study has been approved by the UCL Research Ethics Committee: Project ID Number 8293/003.

What is this study about and why is the research taking place?

We would like to invite you to participate in this study, which is exploring the child psychotherapy service in the [Name of LAC CAMHS]. This study forms part of a PhD project funded by University College London and the Association of Child Psychotherapists, to investigate psychodynamic models of working with looked after children (LAC). The overarching aim is to understand the role and contribution child psychotherapists can make to working in a multi-disciplinary CAMHS team in a LAC social care setting, from the perspectives of child psychotherapists, other mental health clinicians, and social care professionals.

What does participation involve?

As part of the study, the researcher will be observing the child psychotherapy services provided by the [name of LAC CAMHS] (excluding therapeutic sessions with children), as well as conducting interviews with the CAMHS team members and professionals who use the service. During the observation period, the researcher will sit alongside the child psychotherapists in the office and observe their practice at their desk and whilst they conduct any planned or more 'informal' consultations with social workers, such as conversations in the corridors or across desks. If you agree

to participate in the study, the researcher would like to attend your weekly CAMHS team meetings during the observation period, making observation notes on what occurs in the meetings. During the meetings, the researcher will be sitting quietly taking notes. The focus of the observations will be on the services that the child psychotherapists provide to professionals working with looked after children, for example the structure and format of consultations, and possible changes occurring as a result of the consultations. The researcher will also be observing what distinguishes the child psychotherapists' role within multi-disciplinary consultation, and how the consultation service fits within a social care context. No confidential details will be included in the researcher's notes, but you can ask me to pause my observation at any point, if necessary. No observations of therapy sessions with children will take place.

You will also be asked to meet the researcher for an interview. The interview will last around 60 minutes in length and will be digitally recorded. During the interview, you will be asked some questions about the services your team provide to families and professionals working with LAC, and what you think is the contribution that child psychotherapy can make to a LAC social care team.

What are the benefits of taking part?

We hope that the study will provide valuable practice-based evidence for how child psychotherapy is being utilized in a CAMHS team embedded within social care. This study will provide understanding of the child psychotherapists' role in a specialist LAC setting to both the wider child psychotherapy and social care professions.

What are the potential disadvantages of taking part?

As taking part in the research may involve meeting the researcher for an interview, this will have a minor inconvenience on your time.

What will happen to the study data?

Your data will be treated as confidential. The interviews will be transcribed by the researcher; this will include anonymising any personal or identifying details. You will not be asked to provide any personal or identifying details of the families that the service works with, and no details of families will be recorded in the observation notes. Your details will be anonymised in the observation notes. The only occasion in which confidentiality will be breached is if there are any disclosures of harm or malpractice, or potential harm or malpractice, which will be discussed with your supervisor. Data will be held securely on a password protected computer and in accordance with the Data Protection Act (2018). Only the researchers involved in the study will access your data. The data will be retained for the duration of the PhD and then disposed of in a secure manner. Findings from the study will be written up for the PhD thesis, and possibly for publication in academic journals and for presentation at conferences. Although direct quotes may be used, these will be anonymised. With your permission, we would like to retain your contact details after data collection has ended, so that we can contact you for feedback on the study findings prior to publication. Your contact details will be kept securely on a password protected computer and in accordance with the Data Protection Act (2018). We anticipate that you will be re-contacted about the study findings in early 2020.

If at any time you no longer wish to take part in the study, you can notify the researchers and withdraw immediately with no penalty.

Privacy statement

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice: <https://www.ucl.ac.uk/legal-services/privacy/ucl-general-research-participant-privacy-notice>

UCL is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. UCL will keep identifiable information about you for the duration of the PhD research. The lawful basis that would be used to process your personal data will be performance of a task in the public interest.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

The PhD researcher will collect information from you for this research study in accordance with our instructions. The researcher will keep your name and contact details confidential and will not pass this information to UCL. The researcher will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from UCL and regulatory organisations may look at your research records to check the accuracy of the research study. UCL will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details. The researcher will keep identifiable information about you from this study until the PhD research is complete.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Contact information

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Nick Midgley (PhD supervisor)

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Patrick Luyten (PhD supervisor)

Reader at the Research Department of Clinical, Educational, and Health Psychology at UCL

p.luyten@ucl.ac.uk

Information sheet – professionals accessing the child psychotherapy service in the [Name of LAC CAMHS]

Title of project: Psychodynamic models of intervention for looked after children with histories of trauma or maltreatment

This study has been approved by the UCL Research Ethics Committee: Project ID Number 8293/003.

What is this study about and why is the research taking place?

We would like to invite you to participate in this study, which is exploring the child psychotherapy service in the [name of LAC CAMHS]. This study forms part of a PhD project funded by University College London and the Association of Child Psychotherapists, to investigate psychodynamic models of working with looked after children. The overarching aim is to understand the role and contribution child psychotherapists can make to working in a multi-disciplinary CAMHS team in a LAC social care setting, from the perspectives of child psychotherapists, other mental health clinicians, and social care professionals.

What does participation involve?

As part of the study, the researcher will be observing the child psychotherapy services provided by the [name of LAC CAMHS] (excluding therapeutic sessions with children), as well as conducting interviews with the CAMHS team, and professionals who use the service.

If you agree to participate in the study, you may be asked to participate in several methods of data collection:

- During the observation period, the researcher will sit alongside the child psychotherapists in the office and observe their practice at their desk and whilst they conduct any planned or more 'informal' consultations with professionals, such as conversations in the corridors or across desks. Detailed notes will be made of these observations. During the consultation sessions, the researcher will be sitting quietly taking notes. The focus of the observations will be on the services that the child psychotherapists provide to professionals working with looked after children, for example the structure and format of consultations, interactions between professionals during consultations, and possible changes occurring as a result of the consultations. The researcher will also be observing what distinguishes the child psychotherapists' role within multi-disciplinary consultation, and how the consultation service fits within a social care context. No confidential details will be included in the researcher's notes, but you can ask me to pause my observation at any point, if necessary. No observations of therapy sessions with children will take place.
- You may be asked to meet the researcher for an interview, which will last for around an hour in length (maximum 90 minutes) and will be digitally recorded. During the interview, you will be asked some questions about the child psychotherapy service in the [name of LAC CAMHS], including the ways you work with the child psychotherapists, how child psychotherapy input has impacted on your service, and how you see the role of child psychotherapists within social care services.

What are the benefits of taking part?

We hope that the study will provide valuable practice-based evidence for how child psychotherapy is being utilized in a CAMHS team embedded within social care. This study will provide understanding of the child psychotherapists' role in a specialist LAC setting to both the wider child psychotherapy and social care professions.

You may also find it interesting to reflect on these aspects of your work.

What are the potential disadvantages of taking part?

As taking part in the research may involve meeting the researcher for an interview, this will have a minor inconvenience on your time.

What will happen to the study data?

Your data will be treated as confidential. The interviews will be transcribed by the researcher; this will include anonymising any personal or identifying details. You will not be asked to provide any personal or identifying details of the families that the service works with, and no details of families will be recorded in the observation notes. Your details will be anonymised in the observation notes. The only occasion in which confidentiality will be breached is if there are any disclosures of harm or malpractice, or potential harm or malpractice, which will be discussed with your supervisor. Data will be held securely on a password protected computer and in accordance with the Data Protection Act (2018). Only the researchers involved in the study will access your data. The data will be retained for the duration of the PhD and then disposed of in a secure manner. Findings from the study will be written up for the PhD thesis, and possibly for publication in academic journals and for presentation at conferences. Although direct quotes may be used, these will be anonymised. With your permission, we would like to retain your contact details after data collection has ended, so that we can contact you for feedback on the study findings prior to publication. Your contact details will be kept securely on a password protected computer and in accordance with the Data Protection Act (2018). We anticipate that you will be re-contacted about the study findings in early 2020.

If at any time you no longer wish to take part in the study, you can notify the researchers and withdraw immediately with no penalty.

Privacy statement

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UCL is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. UCL will keep identifiable information about you for the duration of the PhD research. The lawful basis that would be used to process your personal data will be performance of a task in the public interest.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

The PhD researcher will collect information from you for this research study in accordance with our instructions. The researcher will keep your name and contact details confidential and will not pass this information to UCL. The researcher will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from UCL and regulatory organisations may look at your research records to check the accuracy of the research study. UCL will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details. The researcher will keep identifiable information about you from this study until the PhD research is complete.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

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Patrick Luyten (PhD supervisor)

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Appendix 15. Study 3 consent form

LONDON'S GLOBAL UNIVERSITY



Study Number: 227718

Participant Identification Number:

CONSENT FORM

Title of Project: Psychodynamic models of intervention for looked after children with histories of trauma or maltreatment

Name of Researcher: Fiona Robinson

Please initial box

1. I confirm that I have read the information sheet dated 20/12/18 (version 6) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in the above study.

 Name of Participant

 Date

 Signature

Appendix 16. Study 3 information sheet for families and opt-out letter

LONDON'S GLOBAL UNIVERSITY



UCL

Information sheet - families

Title of project: Psychodynamic models of intervention for looked after children

This study has been approved by the University College London (UCL) Research Ethics Committee: Project ID Number 8293/003

What is this study about and why is the research taking place?

This study forms part of a PhD project at UCL exploring the child psychotherapy service in the [name of CAMHS]. We are looking at the role child psychotherapists play in providing advice and support to social workers and other professionals as part of their work in looked after children's services. The PhD research has identified that many UK child psychotherapists conduct consultation work with professionals working with looked after children as part of their role, therefore we are now investigating the nature of this work.

What does the study involve?

The study involves interviews with child psychotherapists, social workers, and other professionals in the [name of CAMHS and local authority]. Furthermore, the researcher will be observing consultation sessions between child psychotherapists and professionals such as social workers. During the consultation sessions, the

researcher will be sitting quietly taking notes. The focus of the observations will be on the services that child psychotherapists provide to professionals working with looked after children, for example the structure and format of consultations, and the role the child psychotherapist plays in delivering consultations. The focus is not on the content of the consultation or details of the families discussed during these sessions; no details of children, young people or families will be recorded in the notes.

No observation of therapy sessions with children or young people, or of meetings with children, young people and/or families, will take place. The focus of the research is specifically on how child psychotherapists work with other professionals.

What are the benefits of the study?

We hope that the study will provide valuable understanding of how child psychotherapy is being utilized in a CAMHS team embedded within social care. By the end of the study we hope to be able to demonstrate the ways in which other professions can potentially make use of child psychotherapy services, and use this to inform the design of better services for looked after children and their families.

What will happen to the study data?

All data will be treated as confidential. During the interviews, professionals will not be asked to provide any personal or identifying details of the children, young people or families that the service works with, and no details of children, young people and families will be recorded in the observation notes. Personal or identifying details of professionals participating in the study will be anonymised in both the observation notes and interview transcriptions.

Data will be held securely on a password protected computer and in accordance with the Data Protection Act (2018). Only the researchers involved in the study will access the data. The data will be retained for the duration of the PhD and then disposed of in a secure manner. Findings from the study will be written up for the PhD thesis, and possibly for publication in academic journals and for presentation at

conferences. No details of children, young people or families will be included in the PhD thesis, publications or presentations. Although direct quotes from the study participants (child psychotherapists, social workers, and other professionals) may be used, these will be anonymised.

Contact information

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Nick Midgley (PhD supervisor)

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Patrick Luyten (PhD supervisor)

Reader at the Research Department of Clinical, Educational, and Health Psychology at UCL

p.luyten@ucl.ac.uk

Re: Research study: psychodynamic models of intervention for looked after children

We are writing to let you know about a research study taking place in the [name of CAMHS], and [name of Children's Services]. The study is being conducted by a PhD student at University College London (UCL), and is exploring the role that child psychotherapists play in providing advice and support to social workers and other professionals as part of their work in looked after children services.

Enclosed is an information sheet from the researchers in the study, which gives much more information about what the study involves and what will happen to the data collected. The study participants will be members of the [name of CAMHS], as well as social workers from the [name of social care team], and other professionals who work with looked after children.

We are writing to inform you of the study as it involves a researcher observing consultation sessions between child psychotherapists and professionals such as social workers, during which families open to CAMHS and/or social care may be discussed. As the information sheet explains, the focus of the study is on the services delivered by child psychotherapists and the role they play in providing consultations to other professionals – we want to make it clear that no details of children, young people or families will be recorded in the observation notes, or in any subsequent publications of the research. The research has been approved by the University College London research ethics committee and NHS Health Research Authority.

If you have any questions about the research, you can contact us on the phone number above. If you would prefer that your family is not discussed in consultation sessions observed by the researcher, please sign the 'opt-out' form below and return

I/we have read the information sheet provided on the research study 'Psychodynamic models of intervention for looked after children' and I/we would prefer to 'opt-out' of my details/families' details being discussed during consultation sessions observed by the researcher.

Name(s).....

Signature(s).....

Date.....

it to us at the above address by [date]. If we do not hear from you by [date], the study will commence, and we will we assume that you have no objection to the researcher observing consultations where your child, young person or family may be being discussed. This will not affect the care that you receive by CAMHS and/or Children's Services in any way.

Your sincerely,

[Names of child psychotherapists]

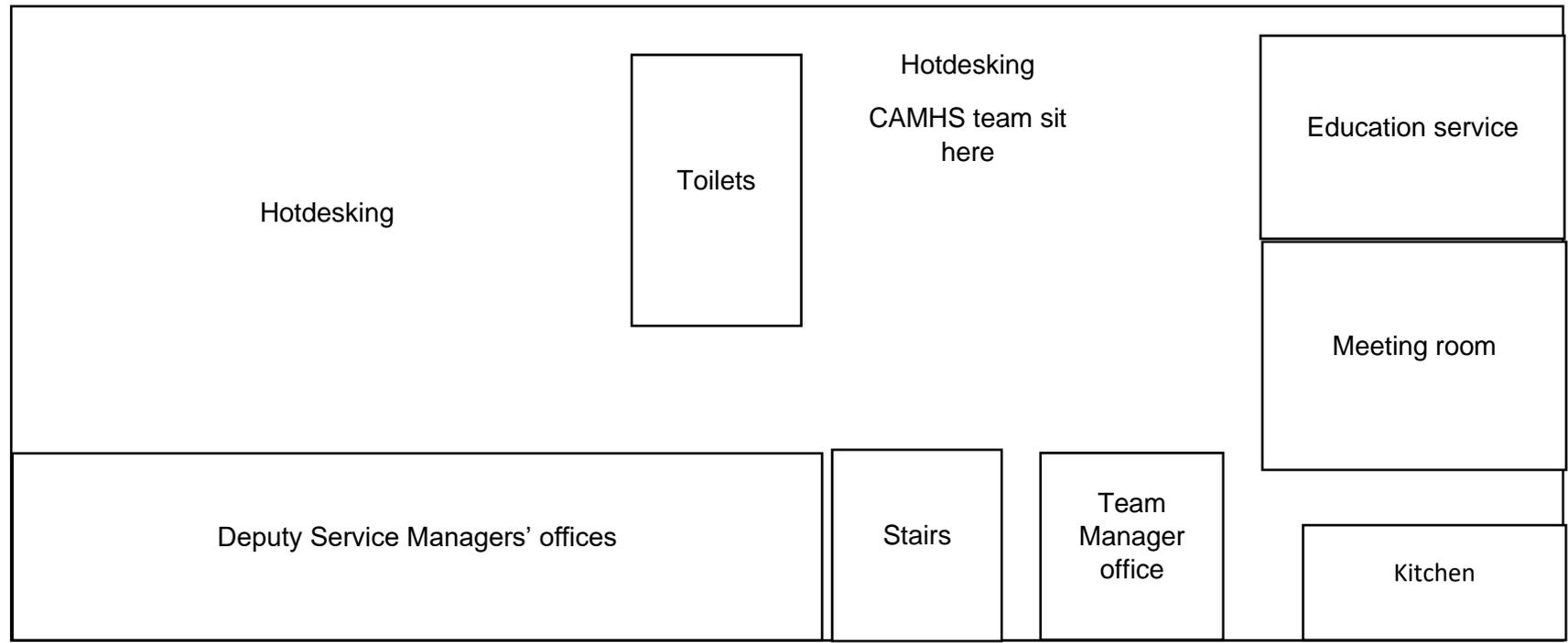
Appendix 17. Study 3 detailed description of the study setting

The majority of observations and interviews were conducted at a CLA and Leaving Care social services office in an inner-city, ethnically diverse area. The office was situated on a quiet, mostly residential side street, nearby a busy high street. The downstairs of the building comprised a large and bright reception area, several meeting rooms and a large kitchen. One of the meeting rooms, tucked away in the far corner of the building, was used by the LAC CAMHS team to hold their team meetings and therapy sessions. The room could be used by other staff at other times, but a diary board pinned to the door designated the days and times it was in use by the CAMHS team as a priority. The CAMHS room was small but brightly furnished with coloured sofas and armchairs, a low table in the centre of the room, and shelves in one corner containing toys for therapy sessions. During observations, I often felt the room was quite dark and cold, and the CAMHS team frequently turned on lamps and used a heater, even in the warm summer months.

The upstairs of the building comprised an open plan office where the social care and CAMHS teams sat. Hotdesking was used throughout for non-management staff. The CAMHS team sat integrated into the social care team, using the hotdesking policy. Although open plan, the office was divided in two by a toilet block, although people could access both sides of the office through a corridor and conversations could be heard on both sides of the wall. One side of the office was lined with small offices for the social care Team Manager and Deputy Service Managers, as well as a small kitchen. The Virtual School (LAC Education service) were also based in this office. *Figure 5* shows a visual representation of the upstairs of the building. As stated earlier, the majority of observations were conducted on Thursdays and Fridays, however by conducting several observations on different days of the week, I observed that the atmosphere in the office differed on different days. For example, on Wednesdays the office was a hive of activity, with the majority of social workers in, and it could be difficult to find a desk on this day. However on Fridays the office was much quieter, with many desks available. A member of the Virtual School commented to me that the office resembled a 'graveyard' on Fridays. From speaking to several people from different teams, this seemed to be because many social workers were out of the office on Fridays, conducting LAC Reviews or visits.

Figure 5

Visual representation of the upstairs office layout



Appendix 18. Study 3 examples from the grounded theory analysis process

1. Examples of initial codes using gerunds (codes describe the child psychotherapists' approach/style of working)

- Acknowledging social workers' feelings
- Asking open questions
- Being direct with social workers
- Mimicking social workers' responses
- Offering an alternative perspective to social workers
- Using emotive language in consultations with social workers
- Reflecting on how the network could have responded differently
- Encouraging network professionals not to be coerced
- Wanting to offer a consultant led approach

2. Initial and focused coding example – moving from initial coding to focused coding

Initial codes	Focused codes
<ul style="list-style-type: none"> • CPT [child psychotherapist] offering perspective of the child's mind to social care • CPT reflecting on the child's experience • CPT acknowledging child's feelings 	Offering perspective of the child's mind and experience
<ul style="list-style-type: none"> • CPT challenging social care's decisions • CPT being direct with social workers • CPT using emotive language to get viewpoint across • CPT persisting with viewpoint • CPT putting viewpoint down in writing – blame management 	Challenging social cares' thinking and decision-making

-
- CPT encouraging network not to be coerced
 - CPT empowering social workers to articulate their views
 - CPT encouraging social workers to see the value in the work they already do
- Emboldening social workers to have a sense of agency
-

3. Example memos

3.1 An early memo on 'The CAMHS perspective' (in vivo focused code, later developed into the sub-category 'CAMHS team identity: 'The CAMHS perspective'')

'The CAMHS perspective' is a phrase used by members of the CAMHS team during consultations with other professionals. Often this is as a means of getting their viewpoint across to other agencies, perhaps to make more of an impact in that this view transcends their individual perspective.

Thinking about what underlies 'The CAMHS perspective' – it means shared decision-making within the team. It means respect for each other's disciplines and valuing the perspectives of other team members. It can mean shared working on cases e.g. one clinician works with the child while another works with the foster carer.

The CAMHS perspective means having the support of team members to sit down and think through aspects of cases in great detail – both during team meetings and informally across desks. Team members value this aspect of their working and feel anxious if they don't have time for it / and 'lonely' when other team members aren't available. A consequence of having this thinking time to process cases in great detail is that team members are intricately aware of each others' cases and can liaise with other professionals in the absence of the main team member working on that case.

The CAMHS perspective in part results from the team being small and 'tight'. Their relationships are built on friendship and camaraderie. There is no hierarchy in the team, the lack of team manager means that no one person makes decisions.

I wonder if using this phrase ‘the CAMHS perspective’ makes them feel more emboldened to challenge the local authority during consultations – knowing that they have the backing of other team members.

On the flip side, ‘the CAMHS perspective’ also means that the team are quite ‘tribal’ and protective over their work, which can lead to frustrations that some of their services have been reduced by the local authority.

To explore further - does ‘the CAMHS perspective’ mean the team sometimes take an ‘expert’ position in consultations?

3.2 A memo on ‘challenging social care’s decision-making’ (later developed into the sub-category ‘investigating, and challenging, thinking and decision-making’)

An integral part of the child psychotherapists’ role is ‘offering another perspective’ to social care. Often this is spoken about (and seems to be perceived by social care) positively e.g. when the child psychotherapist makes interpretations about the child’s communications and feelings.

However, frequently the child psychotherapists have to challenge social workers. They can be very direct in their approach with social workers when they feel strongly that their clinical opinion does not match the local authority’s decision. Sometimes this challenging can be positive – several instances of the child psychotherapist empowering social workers to make decisions (instances in which they felt the local authority was avoiding responsibility as an organisational defence). They use empowering language to give social workers a sense of ownership of their cases (and perhaps to form an alliance with them) e.g. “your department has the expertise to make these decisions”. Both the child psychotherapist and social workers seem buoyed up after these consultations e.g. one worker said “you’ve made me feel like the Men In Black, like superwoman”.

On other occasions there is a sense the child psychotherapists experience a lot of tension in working alongside social care. The CAMHS team discuss numerous instances in which they feel excluded from professionals’ meetings in which important decisions are made. The team reflect on what may underlie this and conclude that their perspective may be too ‘unbearable’ for social care – it will

engage them in thinking about something which is too difficult for them to think about, and therefore easier to avoid. Sometimes the child psychotherapists seem to 'escalate' when they feel their perspective is not being listened to – particularly in their use of language e.g. "it is my clinical judgement she is putting her child at risk". In some cases they have even considered closing CAMHS cases when they feel their clinical opinion doesn't match the local authority's decisions, and they have resigned themselves to the fact that social care won't change the decision.

There are numerous examples of the CAMHS team not being fully integrated into the setting – describing themselves as 'the fostered team' and 'we're all refugees here'.

I get the impression that experienced clinicians are needed for this role, who have the confidence to challenge the local authority's thinking and to keep persevering with their perspective. The effects of this challenging can be very demoralising for the child psychotherapists. Sometimes they are resigned to go along with things that they feel are being forced upon them. I think there is an interesting tension between the power (and burden) of 'clinical responsibility' yet ultimately sometimes it seems as if they are powerless when it comes to legal decision-making.

4. An example of a category and the focused codes it subsumed:

In the final analysis, the first category was 'child psychotherapists multiple professional identities', which contained the sub-category 'CAMHS team member identity: 'The CAMHS perspective''. The focused codes subsumed under this sub-category, mostly related to the functioning and relationships in the CAMHS team, were:

- 'The CAMHS perspective'
- Digesting and processing as a team
- Sharing work amongst team members
- Self-managing team
- Supporting each other as team members
- Discussing their own feelings as a team
- Differences in approach across disciplines
- Feeling excluded from social cares' decision-making

- Feeling unintegrated into the setting
- Feeling resigned to concede to social cares' decision-making
- Having different priorities and position to social care

5. List of topics covered during theoretical sampling interviews:

5.1 Initial list of topics covered during first phase of theoretical sampling

Explore social workers' perceptions of:

- The different positions/agendas of the social care versus CAMHS (e.g. do they feel a burden of responsibility as the corporate parent, that they don't feel applies to CAMHS?)
- The child psychotherapists' approach of encouraging curiosity and tolerating uncertainty.
- Instances in which the CPTs have challenged them (perceived positively or negatively?)
- How they feel about the CAMHS team not taking on all cases for individual therapy.

Explore social care managers perceptions of:

- The changing remit of the CAMHS team over recent years, and the reasoning behind this.
- Decisions to not include the CAMHS team in some decision-making meetings.
- The embedding of systemic practice culture within social care, and what are the implications for the CAMHS team who are from other disciplines.
- The authority of corporate parent responsibility versus clinical responsibility?

Explore child psychotherapists' and other CAMHS team members perceptions of:

- Instances in which they have to take more of an "expert" position (which is in contrast to their typical approach of inviting and encouraging different perspectives).
- How do they negotiate goals with social care when they have different ideas about how to achieve something?
- Do they feel like they sometimes get drawn into battles with social care?

- Whether the tension between CAMHS and social care is a necessary/positive or an incompatible one? In what circumstances is it positive or negative?
- What is the unique contribution of child psychotherapy in the CAMHS team?
- Their perceptions of the authority that clinical responsibility holds within this setting.
- What do other CAMHS team members see as the unique contribution of child psychotherapy within the CAMHS team?

5.2 Questions for the child psychotherapists during second phase of theoretical sampling (once the theory was more substantive but the properties of the categories needed fully saturating)

Regarding the professional network member identity:

- What are the 'characteristics' of this identity from the child psychotherapists' perspective? (i.e. what do they say or do when adopting this identity)
- What do the child psychotherapists think is the impact of this identity?

Regarding the three professional identities:

- In what situations do they feel that one identity dominates?
- Do they think they have modified the identity learnt during their training to incorporate other identities? (is the network member identity an added/new identity?)
- How do they manage working under two regulatory frameworks (NHS and local authority?)

Regarding the four processes the child psychotherapists engage in:

- From the child psychotherapists' perspective, what characterises the differences between the processes of 'challenging thinking and decision-making' and 'facilitating a sense of agency in social workers'?