

**From Out-of-Reach to Outreach: Exploring How Child and
Adolescent Psychotherapists Work in Outreach Settings**

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Dedication

To my parents, for your love, courage, and sacrifices that made this journey possible. You taught me to work hard, lead with kindness, and believe that anything is within reach.

And to the refugee families I worked with in Greece, through you, I came to understand what can happen when psychotherapeutic support meets people where they are, both physically and psychically. You taught me that even when all else fades, an internal home can remain.

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Abstract

This study explores how Child and Adolescent Psychotherapists (CAPTs) work psychoanalytically in outreach and community-based settings. It examines what happens to the psychoanalytic frame when therapy is offered outside the clinic, and how practitioners adapt and sustain their work alongside the communities and institutions in which they are based. Here, outreach refers to therapeutic work delivered beyond traditional CAMHS clinics, in educational, faith, arts, and local organisations. The focus is on what enables engagement, what barriers remain, and how outreach can offer meaningful contact for children and young people who may not or cannot use clinic-based services.

The literature review found significant experimentation in psychoanalytic outreach from the late 1960s onwards, but fewer recent published accounts, making it unclear whether this work has declined or is simply less documented. It found that outreach can widen access while retaining psychoanalytic depth when the frame is adapted thoughtfully. The review also highlighted tensions around professional identity and what is recognised as psychoanalytic, alongside the difficulties of sustaining projects that rely on individual commitment and short-term support.

Semi-structured interviews were conducted with four CAPTs leading psychoanalytically informed outreach projects across different community contexts, and the data were analysed using Reflexive Thematic Analysis. The findings highlight the motivations and conditions that give rise to outreach; how practitioners redefine the therapeutic offer outside the clinic; the emotional texture of the work; and the practical and institutional challenges involved in sustaining it. Participants described a shared commitment to bringing psychoanalytic thinking to children and families who might

not otherwise engage with CAMHS, and to offering depth work in accessible, familiar, and trusted settings. The research shows how containment, boundaries, and symbolic thinking can be held flexibly while maintaining therapeutic integrity.

Outreach emerged as both a clinical and ethical practice, a way of keeping psychoanalytic thinking alive within ordinary community life. The work required creativity, persistence, and collaboration, revealing psychoanalysis not as confined to the consulting room but as capable of meeting young people where they are. This study contributes to a wider understanding of how psychoanalytic psychotherapy can remain relevant, inclusive, and socially engaged within contemporary mental health care.

Keywords: Child Psychotherapy; outreach; community-based settings; psychoanalytic frame; engagement; access

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1 Introduction

This study explores how Child and Adolescent Psychotherapists (CAPTs) work psychoanalytically in outreach and community-based settings. It examines what happens to the psychoanalytic frame when therapy is offered outside the clinic, and how practitioners adapt and sustain their work alongside the communities and institutions in which they are based. The focus is on what enables engagement, what barriers remain, and how outreach can offer meaningful contact for children and young people who may not or cannot use clinic-based services.

1.1 Working Definitions: Outreach and the Psychoanalytic Frame

My working definition of outreach refers to psychoanalytically informed work brought into the settings and communities where children and families already are, rather than relying on them to approach an established clinic or private consulting room. Location is therefore central to this definition. Outreach may take place in schools, nurseries, faith organisations, arts and sports projects, and other community settings that already form part of children's everyday lives. It often develops in response to the recognition that some children and families are not being reached by existing provision or remain at the edges of care, and that another route into psychological help may be needed.

Outreach can also offer greater freedom and flexibility in thinking about how therapeutic contact might begin. The clinician can work at the pace of the child, family or community and consider what might provide a way in. This may involve sport, drama or other creative activities, drawing on faith and community relationships, or using family work and other familiar forms of engagement. The therapeutic offer can develop in relation to the cultural, religious, familial and community frameworks through which children and families understand their experiences. In this sense, outreach involves

meeting families where they are, both physically and psychically, and taking greater responsibility for making psychological help feel possible and relevant.

In this thesis, when I refer to the traditional psychoanalytic frame for working with children and adolescents, I mean work offered within an established institutional or consulting-room setting, including NHS CAMHS, hospital inpatient and outpatient services, and private practice. The precise arrangements vary across these settings and may include individual psychotherapy, parent work, family work or groups. In individual child psychotherapy, the frame is commonly organised around regular sessions with the same therapist, at the same time and in the same private room, often once weekly or more intensively. The child may have an individual box containing consistent materials that are kept safely between sessions, alongside separate parent work and regular reviews with the family. The service or therapist provides an established structure around assessment, frequency, privacy, professional roles, breaks and endings, and children and families are usually expected to engage within these arrangements.

Traditional and outreach work can both remain attentive to unconscious communication, transference and countertransference, symbolic meaning, containment and what is communicated through relationships. Outreach may retain many aspects of the traditional frame, including regularity, consistency and clear boundaries, while allowing other parts of the work to develop more flexibly in response to the setting and the families being reached. The comparison throughout this thesis therefore concerns where the work takes place, how the therapeutic offer is organised, and the direction in which help moves. It asks how psychoanalytic thinking can be sustained when the work moves beyond established clinical settings and into the everyday life of communities.

1.2 Personal and Professional Context

My interest in this work began while developing a trauma-informed programme for children and families in a refugee-camp setting. The work required us to respond to needs as they emerged and to shape the support around the ways families understood their children, rather than assuming that an established model could simply be transferred into the setting. I later worked with refugees and communities affected by the Grenfell Tower fire, including community-based work linked to a local mosque. Over several years, I moved between community projects and more established services, and became increasingly interested in what each could offer.

The idea of community is complex, shaped by culture, faith, class and geography, and can be understood as a relational space informed by unconscious processes and shared emotional life (Liang, Tummala-Narra & West, 2011). From my experience both within and outside CAMHS, I have noticed that many families, for cultural, practical and emotional reasons, avoid or do not seek help from clinic-based services. My own refugee background has also shaped my awareness that families may have very different relationships to psychological help. Some communities may have little familiarity with services such as CAMHS, may not understand their difficulties through psychological language, or may carry mistrust rooted in experiences of institutions and systemic discrimination. National data show that children and young people from minoritised and socio-economically deprived backgrounds remain underrepresented in CAMHS referrals (NHS Digital, 2024). Such figures are unlikely to reflect local need and raise questions about who feels able to approach clinic-based services, who is referred, and who imagines themselves as belonging within them.

A service can be available without necessarily feeling imaginable, safe or relevant to the people it is intended to support. Community-based work raised different possibilities, including whether trust might develop when a clinician enters a setting

already known to families and takes some responsibility for becoming part of the community, rather than placing the full responsibility for engagement on those seeking help.

1.3 Researcher Position and Reflexivity

My experience within CAMHS further developed this interest. I became curious about who was not reaching CAMHS, despite the needs I had encountered in wider community settings. This included families from minoritised communities, as well as young people whose distress might be expressed through externalising behaviour, exclusion, exploitation or serious youth violence. Parker et al. (2019) found that significant psychiatric difficulties could remain unrecognised among children excluded from school. Clinical and review literature also suggests that young people whose distress is expressed through antisocial or disruptive behaviour may be less likely to access or remain engaged in conventional talking therapies (Wells, 2001; Khan, 2016). This led me to think about fit: which forms of help feel usable to different children and families, and what clinicians and services might need to do when the existing offer does not provide a way in.

Alongside questions of access, I came to this research with a particular interest in what happens to psychoanalytic thinking when the work moves beyond the traditional clinic setting. I wanted to understand whether the psychoanalytic frame, once internalised through training and practice, can be carried across settings and used flexibly without losing its depth. This was not only a theoretical question, but one connected to the kind of clinician I hoped to become and my own wish to work creatively across clinical and community settings. I therefore approached the study with curiosity and hope, but also with an investment in the possibility that outreach could remain meaningfully psychoanalytic. I wanted to understand whether community-based

work could be valued as serious psychoanalytic practice rather than being regarded as diluted, secondary or merely applied. Being explicit about this position is important. I was aware that this investment shaped the questions I brought to the study and might influence what I was most ready to notice in the accounts of those taking part. I return to the implications of this position in the methodology and discussion.

1.4 Research Gap and Rationale

Although psychoanalytic outreach has a long history, the literature tends to focus on individual projects in schools, nurseries and other community settings. I did not find empirical research that brings together the experiences of CAPTs working across a range of contemporary outreach contexts. There is also relatively little attention to what makes the work psychoanalytic in these settings – what aspects of the frame can be carried across, what becomes harder to sustain, and what might be gained through working beyond established clinical structures. There is also limited research exploring what motivates CAPTs to develop outreach work, how they use psychoanalytic thinking creatively in practice, and what supports or threatens the continuation of these projects.

This gap provided the rationale for the study. It seeks to understand how CAPTs are using psychoanalytic thinking across varied community settings, what happens to the frame as the work moves beyond the clinic, and how outreach may widen access to psychological help. It also considers what psychoanalytic practice itself might learn through closer engagement with communities whose understandings of distress, relationships and care may not readily fit established clinical language.

1.5 Aims and Objectives

In light of these questions about access, containment and adaptation, the study is guided by the following aims and objectives:

- (1) To explore how CAPTs adapt psychoanalytic work and sustain the therapeutic frame outside the clinic.
- (2) To understand the motivations and conditions that give rise to psychoanalytic outreach interventions.
- (3) To examine how psychoanalytic thinking can be used flexibly to meet the needs of diverse groups of young people.
- (4) To understand the barriers faced by young people who may not access CAMHS because of stigma, anxiety, or preference for more familiar community settings.
- (5) To consider the benefits, challenges, and limitations of this work across services and systems.

By exploring how CAPTs sustain psychoanalytic thinking in community contexts, this study contributes to a broader understanding of how psychoanalytic psychotherapy can remain relevant and accessible in contemporary services. It seeks to document current practice and highlight both the possibilities and tensions of adapting psychoanalytic work beyond the consulting room.

2. Literature review

2.1 Introduction

This review considers the literature on psychoanalytically informed work with children and young people in outreach and community settings from the last thirty years. Much published literature derives from clinic-based practice, yet barriers such as thresholds, waiting lists, stigma and cultural obstacles leave many families excluded. Outreach models have developed in response, bringing therapy into schools, nurseries and community settings.

The purpose of this review is to bring together the available literature on psychoanalytic outreach work. It considers how the frame has been described beyond the clinic, its value and limitations, and the professional experience of outreach work, including motivations, interventions, and the challenges involved. A recurring question is where the borders and boundaries of such work lie when compared with CAMHS provision.

For the purposes of this study, the term psychoanalytic psychotherapy includes psychodynamic approaches, with an emphasis on transference – the re-emergence of earlier emotional patterns within the therapeutic relationship (Freud, 1912/1958; Joseph, 1985), unconscious communication, and the use of the therapeutic frame, understood as the reliable structure that provides containment and makes symbolic communication possible (Langs, 1978; Alvarez, 1992; Rustin, 2003; Coren, 2010). Containment, in Bion's (1962) sense, refers to the therapist's capacity to receive and process projected emotional states so they can be thought about rather than acted out, a concept central to much of the outreach literature discussed below.

A question raised by much of the literature is how far these core aspects can be kept or adapted outside a clinic, where the same room, time and anonymity are easier to maintain. Outreach is defined here as work delivered outside of outpatient CAMHS clinics, often in community-based or educational settings, unlike broader community

psychology and psychiatry, which are often non-psychoanalytic and outcome-focused. The process of searching confirmed that a clear majority of empirical studies have focused on treatment outcomes, drop-out rates or predictors of engagement, with far fewer examining the experiences or clinical practice of therapists working psychoanalytically in outreach settings. This review therefore focuses on literature that illuminates the lived and clinical experience of psychoanalytic work in outreach, rather than on outcome or efficacy studies.

This review addresses the following questions:

- (1) How has psychoanalytic psychotherapy been adapted and described in outreach and community settings for children and young people?
- (2) What challenges and opportunities are identified when psychoanalytic work takes place outside the clinic?
- (3) What does existing literature suggest about the value, limitations, and sustainability of such work, and about the experiences of clinicians who deliver it?

2.2 Literature search

Searches were run in major psychology, health and education databases in April and August 2024. A full account of the search process, including the PRISMA flow diagram, is provided in Appendix A/B.

Table 1
Boolean search structure.

Search Focus	Example terms used
Clinical modalities (S169)	(psychoanalytic psychotherapy or psychodynamic psychotherapy) OR community-based psychotherapy NOT (psychiatry or psychiatric) NOT family therapy NOT (CBT or cognitive behaviour* therapy or cognitive behavio* therapy) NOT (art therapy or art psychotherapy or creative arts therapies or expressive arts therapy)
Outreach settings (S167)	psychoanalytic project OR (community based or community-based or community program or community orientated or community focussed, or community engaged) OR community mental health OR (community setting or community-based intervention or community project) OR (third sector or nonprofit or charity) OR (outreach programs or outreach services or community outreach or outreach project)
Population (S168)	(children or kids or child) OR (young people or youth or adolescents or young adults or teenagers)
Combined search	S167 + S168 +S169

The inclusion criteria are set out in the table below.

Table 2
Inclusion criteria

	Inclusion
1.	Children and young people aged 0–25, including work with parents when linked to the child
2.	Outreach or community-based settings (schools, nurseries, youth groups, charities, residential/secure units, parent–infant services, home-based work)
3.	Psychoanalytic or psychodynamic modality, or interventions explicitly informed by psychoanalytic thinking
4.	English language, full text available

The search process and refinement stages are summarised in Table 3. In total, 98,258 records were identified across databases and progressively narrowed through relevance and quality filters to 226 papers for detailed screening. Publications ranged from 1970 to 2023.

Table 3
Search Refinement Process

Stage	Criteria Applied	Records Remaining
Initial combined search	All databases	98,258
Peer-reviewed academic journals	Excluded grey literature	81,565
Subject relevance (modality/discipline)	Psychoanalytic or psychodynamic focus	20,779

Age filter (0–25 years)	Children, young people, young adults	1,561
Setting/speciality relevance	Outreach, community or educational contexts	483
English language and full text access	Limited to English language, full-text papers	344
Final screen (journal papers only)	After duplicates and nonpeer-reviewed removed	226

After screening titles and abstracts, 142 papers were excluded as unrelated, leaving 84 for retrieval. Following full-text review, 48 papers and chapters were identified as relevant, of which about 30 were prioritised for detailed inclusion. Papers were excluded if they focused on outcomes rather than clinical practice, were not delivered by child and adolescent psychotherapists, or did not clearly describe how psychoanalytic ideas were applied. Some were removed at the abstract stage, and others after closer reading, when it became clear they did not address the practice-based focus of the research question. The 30 papers and book chapters retained were selected because they directly explore psychoanalytic practice in non-clinical settings and contribute to answering the research question.

As Aveyard (2014) and Greenhalgh (2014) explain, hierarchies of research design place systematic reviews and randomised controlled trials at the top of the evidence scale, with descriptive studies, case reports and expert opinion towards the lower end. In this search, the literature on psychoanalytic outreach consisted of clinical papers, reflective accounts and books rather than controlled studies, with only two programmes identified (FIRST STEPS, Lebigier-Vogel et al., 2019; and New Beginnings, Baradon et al., 2008) evaluated through randomised trials.

While this means the findings cannot be generalised in the way higher-level evidence allows, these texts remain the most relevant for a study concerned with the

practice of CAPT's in community settings. They offer detailed accounts of how psychoanalytic work has been attempted and adapted, which is precisely what this review aims to explore. This inevitably limits the strength of claims but also highlights how little psychoanalytic outreach has been researched and why practice-based accounts remain important sources of knowledge.

2.3 Structure and Scope of the Literature Reviewed

The following section outlines the structure and scope of the literature reviewed. Part I begins with the early history of psychoanalytic outreach, including work in Vienna and London, and then moves through UK-based developments in schools, parent–infant and early-years interventions, and community projects. Part II then turns to how this work has been thought about – the debates on technique, identity and adaptation, and the questions these raise for psychoanalysis beyond the clinic. Together, the two parts aim to map both the practice and the discourse of outreach, before drawing out the themes that run across them and the gaps that remain.

2.4 Part I – Psychoanalytic Outreach in Practice

2.4.1 Historical roots of psychoanalytic outreach

In its early years psychoanalysis took place almost entirely in private consulting rooms. Patients came to Freud in Vienna, and the tradition grew out of people actively seeking analysis, however conflicted their reasons may have been. During the Second World War, Klein (1945), analysed Richard while living in temporary accommodation and Anna Freud set up the Hampstead War Nurseries for children separated from their families (Freud & Burlingham, 1943). Both examples showed how psychoanalysis could be taken into new and difficult contexts when children's circumstances required it.

After the war, child psychotherapists were employed in Child Guidance Clinics. These were originally funded by education budgets rather than the NHS, which kept the work closely tied to schools. With the creation of the NHS in 1948, psychoanalysis became more embedded in public health systems and later in CAMHS.

Education and psychoanalysis remained closely connected in these decades. Jenkins (2021) notes that many of the first child psychotherapists, including Anna Freud and Susan Isaacs, had backgrounds in teaching. Anna Freud moved away from early progressive experiments and focused on helping mainstream teachers develop a deeper psychological understanding of children in a developmental context. Isaacs also bridged psychoanalysis and education, shaping both teacher training and parenting advice. At the Tavistock, Esther Bick and later Martha Harris, themselves former teachers, developed consultation models for schools. Harris and O'Shaughnessy's work at Woodberry Down in the 1960s showed how teachers could think with psychotherapists about children and about the emotional strains of teaching itself (Harris, 1968, cited in Jenkins, 2021).

In the late 1960s and 70s, new services such as the Brent Centre for Young People, Open Door, and the Brandon Centre brought psychoanalysis into community settings, offering more flexible and accessible routes for adolescents (Novick, 1977; Baruch, 1995, 2001). At the Tavistock, a Day Unit (later Gloucester House) created a multidisciplinary model where education and therapy were integrated (Boston & Daws, 1977). By the 1970s and 80s, group psychotherapy was also being offered in primary schools, reflecting its natural fit for children struggling with friendships and peer dynamics (Reid, 1999).

During the same period psychoanalysts were also adapting their techniques to reach children who might otherwise be considered unreachable. Alvarez (1992) described ways of modifying her approach when working with autistic and very

deprived children. Her work shows how the field has shifted in both its preoccupations and its specialisms: from Freud's early patients with hysteria, through Klein's explorations of neurosis and psychosis in children, to Alvarez's work with autism and deprivation. Outreach work can be seen as part of this same tradition of extension, meeting children in new places and states of mind, while keeping the focus on unconscious life in relationships.

This trajectory continued into the 2000s, with the Tavistock Outreach in Primary Schools (TOPS) project (Music, 2008; Jenkins, 2021), which expanded psychoanalytic work into Camden schools and laid the groundwork for later developments in educational outreach.

2.4.2 Therapeutic work in schools

Schools are the most extensively documented setting for psychoanalytic outreach. For many children, school is the most consistent setting in their lives, and psychoanalytically informed projects have long recognised both the opportunities and the strains this creates. Jackson (2009) described how the frame and transference could still be held within a school environment, even amid classroom life. Youell (2006) points to the ways psychoanalytic thinking can support teachers to see behaviour as emotionally and developmentally meaningful, rather than simply disciplinary. She stresses the value of observation and of a shared language that helps schools contain the pressures placed on staff. Canham (2006), writing on schools as institutions, suggests that the everyday life of classrooms, playgrounds and corridors can be read psychoanalytically, revealing unconscious and group dynamics. From this perspective, schools offer both a vantage point on children's social worlds and a challenge to therapists to hold onto a psychoanalytic stance in environments not designed for it.

Early accounts also recognised both the possibilities and strains of school-based psychotherapy. Jackson (1970) described her work in a day school for "maladjusted"

children, noting the constant pressures on the therapeutic frame when sessions took place alongside daily school life. Drawing on her experience, Jackson (1970) offered practical guidance on how psychoanalytic work could be sustained outside a clinical setting. She stressed the importance of protecting the therapy space from outside interference, ideally with a room separate from classrooms, and challenged the assumption that psychotherapy was ineffective when children's external circumstances could not be improved. She argued that the task was to help children recognise how their internal experience of deprivation continued to affect their current feelings and relationships, and that working with this inner world could allow for new adaptations, even when the external world remained difficult.

The Tavistock Outreach in Primary Schools (TOPS) project, described in detail by Argent (2021), offers one of the most comprehensive accounts of this work. TOPS embedded child psychotherapists in Camden schools, working not only with children but also with teachers, parents and staff. Sessions took place in classrooms, playgrounds and lunch halls as well as therapy rooms, prompting reflection on how the frame might be sustained outside a traditional setting. The authors suggest that what preserved the frame was not location but the therapist's consistent presence, capacity to think symbolically about events, and collaboration with school staff (Jenkins, 2021; Argent, 2021). The familiar school setting often made therapy more accessible to families who would not have attended CAMHS. Stigma, past experiences of non-attendance, and the practicalities of travelling to a clinic were all barriers, while the everyday presence of a therapist in school reduced threat and encouraged engagement (Jenkins, 2021).

Audit data showed high levels of complexity among the families seen, yet attendance remained consistently strong (Cioeta & Catty, 2021). Children seen were broadly representative of the local school populations, with 28% Black African/Caribbean and 11% mixed-heritage backgrounds, higher than borough averages,

suggesting the service was “engaging well with families from minority ethnic backgrounds” (Cioeta & Catty, 2021, p. 229). Teachers and parents reported changes across four areas: children’s ability to form friendships, improvements in emotional regulation, calmer family communication, and greater capacity for learning. Some of the most important psychoanalytic shifts were hard to evidence in outcome measures. The authors also note the limitations of the audit – outcome data were incomplete and relied largely on teacher and parent reports, offering a partial picture shaped by the realities of practice rather than research design.

Teachers and staff valued the consistent presence of CAPTs, describing therapy rooms as symbolically important spaces and the clinicians’ role as supportive in managing risk and emotional strain (Jenkins, 2021; Cioeta & Catty, 2021). In this way, the psychotherapist was not a remote specialist but part of the school’s ongoing task of containment.

For Argent (2021), the distinctive contribution of psychoanalytic psychotherapy in schools lay in its sensitivity to unconscious communication and to the links between present difficulties and developmental history. This required adapting practice to the realities of the school while holding boundaries in mind. Argent (2021) argued that while some families valued the privacy of clinic-based therapy, others engaged more readily in school settings where help felt part of everyday life and where the familiar environment reduced barriers to engagement. Rather than representing a hierarchy of better or worse provision, these approaches can be seen as complementary parts of a wider ecosystem of care, each suited to different children and families depending on their needs and readiness for therapy.

Other accounts highlight the difficulties as well as the opportunities. Essenhigh (2001) stresses that it was essential for the therapist to be embedded in the school system rather than merely based there. She described work in a secondary school for

pupils with severe emotional and behavioural disturbance, where therapy reached young people unlikely ever to access CAMHS. She reflects that while this widened access, it often bypassed parents, unlike clinic-based or primary school models where parents are drawn into assessment. Therapy was sometimes perceived as a punishment for bad behaviour, and the absence of parental involvement meant underlying despair risked being overlooked. Essenhugh (2001) concluded that for some adolescents, group or structured approaches might be more suitable than individual psychotherapy in such settings.

McLoughlin (2010) has written about psychoanalytic work in Pupil Referral Units (PRUs), working with children permanently excluded from mainstream schools. The frame had to be adapted, with the therapist's own containing presence becoming the main anchor when the environment itself was unpredictable. McLoughlin (2010) described this as "concentric circles of containment" (p. 227), with support extending from the child to parents, to staff, and to the wider professional network. Work discussion groups for teachers became central, offering space to think about projections and the emotional impact of the children's behaviour, helping staff move from punitive to more reflective responses.

The literature on schools is the most extensively documented area of psychoanalytic outreach, largely through a small number of long-running services such as TOPS and projects at the Tavistock. This body of work reflects the imagination and commitment of individual clinicians who recognised schools as fertile ground for psychoanalytic thinking, rather than a widespread demand from schools themselves. It highlights both the possibilities and the dilemmas of working psychoanalytically in educational settings: how to hold a stance in multipurpose spaces, how to involve parents, and how to demonstrate value in languages that schools and funders will recognise without losing sight of what is most distinctive in the work.

2.4.3 Parent–infant and early years work

Daws (1985) offers one of the earliest accounts of psychoanalytic outreach in infant and family settings, describing her position within a busy baby clinic. Stationed by the weighing scales, she noticed how this ordinary procedure could come to represent the “total state of development” (p. 79), charged with emotional as well as clinical meaning. Her presence among health visitors and GPs allowed her to observe and reflect while remaining available to colleagues who valued her thinking.

Working as the only psychotherapist in a multidisciplinary space, Daws (1985) explored the tension between being part of the clinic and maintaining a distinct analytic function. Silence and observation could be mistaken for passivity, yet they were central to her task of holding the emotional life of the setting and creating space for reflection amid the busyness of everyday work. From her position beside the weighing scales, she found that being visibly available, receptive, and physically present at the centre of the clinic helped her to integrate while remaining separate. She discovered that small, ordinary interactions – brief conversations, shared observations, and reflective meetings could transform her stance into a containing intervention for staff as well as parents. She described the paradox of being both embedded and separate: close enough to notice what unfolded between families and staff, yet distant enough to think about it. This position, she suggested, gave outreach its particular value, enabling countertransference patterns within the team to be recognised and contained through regular staff reflection.

The later development of parent–infant psychotherapy (PIP) continued this outward-facing stance, bringing psychoanalytic work into homes and community spaces. Writers such as Pawl and St John (2002) and Stern (1998) show how early parenthood often requires meanings to be expressed through action and gesture rather than interpretation alone. For outreach, this demonstrates that psychoanalysis can extend

beyond the consulting room when actions are thought about symbolically and grounded in transference and containment.

Structured preventative programmes developed this approach further. The FIRST STEPS project in Belgium and Germany (Lebiger-Vogel et al., 2015) combined psychoanalytically informed parent groups with children's play for immigrant families. Around 180 families were followed through early life, assessing parent-child interaction, attachment and social integration. A later outcome study (Lebiger-Vogel et al., 2019) found improved maternal sensitivity and child responsiveness in the psychoanalytic group, although other areas showed less change. The trial was small and only partly reported, yet it remains a rare example of psychoanalytic outreach evaluated empirically, showing how reflective practice can translate into measurable outcomes.

Similarly, the New Beginnings programme at the Anna Freud Centre, developed with the HMP service (Baradon et al., 2008), worked with mothers and babies in prison. Sessions ran in small groups of up to six mothers and infants, eight two-hour meetings over four weeks, held on cushions at the baby's level so the infant was always present. Group discussions gave space for feelings usually hidden or stigmatised, while the prison environment could feel both containing in its routines and frightening in its shutdowns and crises. The manualised programme, evaluated through a cluster controlled trial, showed increases in maternal reflective functioning (Baradon et al., 2008). Containment for clinicians, through supervision and partnership with prison staff proved essential to sustaining therapeutic thinking in such an extreme setting.

Other projects-built partnerships with professionals already trusted by families. In the Midwives and Mothers project in France (Stoleru & Morales-Huet, 1988), psychotherapists accompanied midwives on home visits with socially vulnerable pregnant women. The midwives' established relationships provided a bridge into therapy, with psychotherapists offering supportive listening and, where possible, follow-

up sessions. Engagement itself often became the therapeutic task, especially for families who had previously refused psychiatric help. The home setting, unfamiliar to many therapists, became a necessary point of access, allowing mothers to receive support they might otherwise have missed.

Crasnow et al. (2020) describe another early-years initiative at the Anna Freud Centre, bringing psychoanalytically informed parent–toddler groups into homeless hostels. Sessions were informal and drop-in, centred on play, songs and conversation, with analytic attention to parents’ anxieties and children’s development. Facilitators maintained a consistent, containing presence even when attendance was erratic and the environment noisy, holding the frame while staying responsive to families’ needs. Parents began reflecting more on their toddlers’ feelings and capacities, and staff observed that the shared play space created moments of belonging and normality.

Across these examples, psychoanalytic work in the early years demonstrates striking adaptability – from baby clinics to prisons and hostels – while retaining its concern with unconscious communication and reflective space. What unites these projects is a willingness to meet families in ordinary, sometimes chaotic settings, to collaborate with other professionals, and to allow action as well as words to carry meaning. Far from diluting psychoanalysis, such adaptations show its capacity to remain alive and relevant in the earliest stages of family life.

2.4.4 Community-Based and Adolescent Outreach

Much of the outreach literature focuses on schools and early-years settings, but a range of community-based projects show how psychoanalytic ideas have also been adapted beyond CAMHS. These examples explore how therapists extended their work into less formal settings, developing new forms of adolescent outreach and community-based practice.

The Brandon Centre was one of the first community-based psychoanalytic services for adolescents in London (Baruch, 1995, 2001). From the outset, it combined clinical work with systematic evaluation, using regular audits to track engagement and outcomes. This process, while demanding, shaped the Centre's thinking about technique and service design. Audit data revealed clear patterns: older adolescents with internalising difficulties were more likely to remain in therapy, whereas younger clients with conduct problems tended to disengage early (Baruch, 1995). In response, the Centre developed new interventions for young people at risk of exclusion, including a randomised controlled trial comparing CBT with supportive counselling for adolescent offenders. Wells (2001) describes how this strand of work was designed for young people whose antisocial behaviour made traditional psychotherapy inaccessible. Although structured behaviourally, the approach retained a psychoanalytic ethos, aiming to foster reflection, accountability, and emotional understanding. Wells (2001) noted that clinicians needed to keep realistic expectations and avoid "the twin traps of collusion or being a critical authoritarian figure" (p. 134), highlighting the balance between accessibility and containment that psychoanalytic outreach demands.

In the 1970s, Novick (1977) described the rise of adolescent walk-in clinics, then seen as a progressive way to reach young people who might never seek formal help. The Brent Consultation Centre, initially a volunteer service, was shaped around adolescents rather than professionals: it was free, confidential, and had no referral routes. Although sometimes dismissed as offering only brief advice, Novick found the opposite; many adolescents presented with severe disturbance, including depression, suicidality, and psychosis. Hurry (1986) later described how the work itself was adapted: consultations were brief and flexible, often around ten sessions, sometimes weekly or fortnightly, depending on what the young person could manage. As Novick

(1977) observed, the clinician's first task was not interpretation but enabling the adolescent to return, to make it possible for a young person to become a patient at all.

Both Novick (1977) and Hurry (1986) highlighted the countertransference pressures stirred by this level of disturbance. Adolescents projected intense feelings that could leave staff feeling hopeless or overwhelmed, making organisational support essential so these projections could be contained rather than enacted. They also raised questions of sustainability. Hurry (1986) cautioned against clinicians working full-time in walk-in settings given the intensity, while Novick (1977) emphasised the need for personal analysis to withstand what he called "the onslaught of the adolescent's feelings" (p. 87). There were differences of view about continuity: Novick (1977) argued the first interviewer should continue as therapist, while Hurry came to see transfer as potentially beneficial, helping adolescents face separation rather than avoid it. These debates reflected the broader reformist spirit of the 1970s, when psychoanalytic practitioners were testing new ways to bring their work into community and youth services. Some models, including Brent and the Brandon Centre, have endured, while others have not, suggesting that sustainability often depends on the institutional support and persistence of those involved.

Other initiatives have embedded psychoanalytic ideas within ordinary community life. Grow2Grow, in Kent (Conway & Clatworthy, 2015), combined therapeutic key working with vocational training on an organic farm for young people who were NEET and often excluded from traditional services. The farm environment offered a non-stigmatising space that balanced structure with emotional support. Staff trained in a psychodynamic model worked alongside young people, taking part in the daily routines of farm life while providing individual sessions. A prominent feature was persistence in engagement: staff phoned, collected, or re-established contact with young people who missed sessions. Although this departs from conventional psychoanalytic

neutrality, it was understood as necessary to counter the pull of withdrawal and to sustain a link with those most at risk of exclusion. The paper focused primarily on outcomes and vocational elements, leaving the detail of the therapeutic process less visible, yet it demonstrates how psychoanalytic thought can be woven into everyday activity.

Hurley (2010) described a smaller project for pregnant teenagers and young mothers, embedded in a community service offering health, education, and housing support. Psychoanalytic input was offered flexibly through home visits and a weekly lunch club, alongside a shared meal that made the setting feel less clinical. Hurley (2010) observed that this mix of provision was often easier to engage with than a “singular diet of emotional help” (p. 102). Drawing on ideas of mourning and reparation, she explored how early parenthood could evoke complex feelings about dependency and care. Her account illustrated how psychoanalytic work can coexist with practical provision, though it also raised questions about whether such roles serve as preparation for CAMHS referral or as therapy in their own right.

Across these projects, psychoanalytic work in community contexts shows both flexibility and fragility. Each initiative reinterprets analytic ideas of containment, reflection, and persistence within environments that demand accessibility and adaptability. What links them is a wish to meet young people where they are and to hold a psychoanalytic stance within the ordinary fabric of community life. While enduring services such as Brent and Brandon indicate the viability of institutional commitment, smaller initiatives often rely on local innovation, making their continuity uneven. Yet qualities such as persistence, tolerance of uncertainty, and faith in the communicative value of engagement emerge as central to success, shaping what child psychotherapists view as necessary for this work to endure.

2.5 Part II – The Discourse on Psychoanalytic Outreach

2.5.1 What makes this psychoanalytic?

Before turning to debates about outreach, it is important to consider what makes the work psychoanalytic in the first place. Although psychoanalysis and psychodynamic psychotherapy are often used interchangeably, there are important distinctions.

Psychodynamic work usually refers to approaches influenced by psychoanalysis but adapted in form, often briefer or less intensive. Child psychoanalytic psychotherapy, even when offered in outreach, is concerned with unconscious processes and the therapist's capacity to contain and think about projections (Bion, 1962).

Joseph (1985) emphasised that transference must be understood as part of the “total situation,” extending beyond the immediate dyad to include organisational and contextual dynamics. Psychoanalytic organisational writers have long explored how institutions take on an emotional life of their own. Halton (1994) described how splitting and projection are not confined to individuals but form part of the institutional process, suggesting that organisations become containers for the anxieties and projections of those who encounter them. These unconscious dynamics shape how authority, care and power are experienced, giving rise to what might be thought of as an institutional transference, in which the organisation itself comes to be felt as punitive, neglectful or protective. This links closely to what might also be understood as an institutional gaze – the way institutional settings can evoke feelings of being seen, judged or defined, shaping how help is experienced and whether it feels emotionally accessible.

Ideas rooted in Freud, Klein, Anna Freud, Winnicott, Bion and Meltzer remain central to how child psychotherapists think and work. Bion's (1962) notion of containment and “learning from experience” is particularly relevant in outreach, where therapists may encounter raw, unprocessed states of mind. Klein's (1940) account of

ambivalence and the depressive position also helps therapists tolerate and interpret the coexistence of love and hate in the same relationship.

These concepts are not always articulated in outreach work but remain present in the way therapists think and respond. What makes outreach psychoanalytic is not the room or the building, but the way what is unconscious is noticed, thought about, and worked with in relationships with children, families and communities.

2.5.2 Psychoanalysis beyond the clinic: Identity, setting, and survival

Having set out these foundations, the review now turns from what has been done to how that work has been thought about. When psychoanalytic psychotherapy moves outside the clinic, the questions are not only practical but also ethical and conceptual: what is protected, what is adapted, and what is transformed in the process. The writers gathered here approach this tension from different angles.

Shuttleworth (1999) describes the shift from institutions where psychoanalysis was central to services where it became only one strand of thinking, affecting both clinical practice and organisational culture. He uses the idea of “dual citizenship” (p.30): child psychotherapists as “border people” holding “dual identities” and “dual languages” (p.31) to move between two professional cultures with different customs, needing a footing in both for the work to survive. He also points to the difficulty of writing about such work: accounts that focus only on unconscious conflict risk sounding irrelevant to colleagues, yet “multi-causal” explanations (p. 36) risk erasing the analytic dimension. The balance is fragile, and Shuttleworth suggests it can be sustained only by what he calls an “internal friendship” between an object that loves psychoanalysis and one that loves social commitment” (p. 48). His reflections remain relevant to outreach today, where clinicians navigate movement between cultures that either centralise or marginalise psychoanalysis.

Bargawi and O'Dwyer (2016) describe a similar challenge as therapists leave the safety of the clinic and enter new community cultures. Child psychotherapists must demonstrate their value to GPs and health visitors while engaging families unfamiliar with psychotherapy, often holding “three hats” at once – members of a GP team, grounded in a psychoanalytic model, and responsive to local context (p. 84). Emanuel (2016) adds that therapists may feel like visitors in unfamiliar institutions, sometimes displaced or overwhelmed in ways that echo families’ experiences of migration. She argues that part of the task is to attach to the outreach setting enough to offer a sense of home in mind, while carrying a “portable toolkit” of psychoanalytic identity (p. 69).

Music (2004) develops this theme, reflecting on the unease and opportunity of leaving the “mole-hole” of consulting rooms (p. 289) to establish services in schools and with looked-after children. Psychoanalysts, he notes, are trained to distrust action, sometimes seeing it as a manic defence or “second skin” (Bick, 1968). Building community services requires compromise: negotiating with sceptical agencies, addressing concerns about elitism, and containing organisational as well as individual anxiety. Drawing on Sartre’s image of molten material that must be shaped while still hot (p. 300), he argues that if analysts wait until structures solidify, they risk being out in the cold. Adaptation, for him, does not dilute psychoanalysis but keeps it alive within changing systems.

Altman (2009, 2013) goes further, describing the consulting room as a “historical artefact” (2009, p. 1) that has traditionally drawn a narrow patient group—those with resources, familiarity with therapy and access to clinics. He argues that this focus excludes those most in need: people facing poverty, discrimination, untreated illness or war. To confine psychoanalysis to those who can reach us, he warns, is to collude in a defensive model of care that insulates the profession from suffering. For Altman (2009), moving beyond the office raises questions about the frame, yet he

maintains that the real anchor lies not in the outer frame but in the analyst's inner attention to transference and countertransference, which may be heightened in moments of chaos. He also challenges the cultural narrowness of the analytic stance, suggesting that the reserved, silent analyst reflects a Western, middle-class culture that risks exclusion. His argument is therefore ethical as well as clinical: adaptation is not dilution but a necessary broadening of the field, enabling psychoanalysis to meet people where they are. If analysts remain in what he calls the "ivory tower" of the consulting room, psychoanalysis itself risks stagnation; by stepping into unfamiliar settings, it can evolve, becoming more culturally responsive while deepening, rather than weakening, its core technique.

The tension between purity and adaptation has been present since the origins of psychoanalysis. Freud (1919) suggested that the "gold" of analysis might sometimes need to be alloyed with the "copper" of advice or suggestion if it is to reach those who would not otherwise benefit from it. His argument was not for purity but for application: that analysis should be taken into the world, finding forms through which its essence could have effect. In that light, contemporary outreach work can be seen not as a departure from psychoanalysis but as a continuation of this early call to extend its reach.

2.5.3 Psychoanalysis in Schools: Opportunity or Dilution?

The case of Sam, a 14-year-old boy seen for therapy in his school, prompted lively professional debate in the ACP Journal (Music, 2009) about what it means to practise psychoanalysis outside the clinic. Jackson (2009) argues that psychotherapy can and should extend beyond outpatient clinics into community settings, yet he notes the challenges of maintaining the frame, sustaining long-term therapy, working in isolation, and holding multiple roles while also building relationships with staff and parents. For Jackson (2009), the question is how therapists remain anchored in their role, attending to the transference and its many manifestations (p.307). Even so, Jackson (2009) brings

attention to the opportunities these settings present to engage families and professionals who might otherwise be missed, and to the “development of the clinician’s autonomy and authority that follows from practising beyond the clinic” (p.305).

Jackson (2009) also notes that analytic work can look and feel different in schools. Teams may be smaller, colleagues less familiar with psychoanalytic thinking, and the transference harder to hold. The familiar intensity of analytic work – acting out, absences, and the “worse before better” process may be harder to manage in this context. Schools can pull the work towards concrete aims. Jackson’s remedy is regular supervision and partnership with staff to sustain an analytic stance. The task is to preserve child psychotherapy’s distinctive capacity to “bear the brunt of what our patients’ objects have never properly been able to face or take responsibility for”, which he sees as a “fundamental source of lasting internal change” (p.307).

Other writers question whether such work is psychoanalytic at all. McLoughlin (2009), a child psychotherapist in a school service, describes debate about whether the adaptations required by school culture dilute the work, leaving it closer to psychodynamic or supportive psychotherapy (Rockland, 1989, cited in Kernberg, 2004) than long-term analytic practice. McLoughlin (2009) also voices unease about providing therapy in schools mainly because parents cannot or will not engage with CAMHS. She argues that the absence of parental involvement can leave children vulnerable to retraumatisation (p.309). This highlights a core tension: outreach is often used when parents cannot easily engage with services, but McLoughlin reminds us of the risks of doing deep work without enough scaffolding in place. This speaks to a live debate about whether outreach is sometimes “better than nothing,” and whether parental involvement should be considered essential for therapy to be safe and effective.

Her reflections connect with wider professional debate about what counts as “real” psychoanalysis. Some argue it is only “pure” when centred on interpretation

within a tightly held frame, with other forms dismissed as preparatory or diluted. Yet Freud himself cautioned against such rigidity, noting that analysis may need to be adapted if it is to remain of practical use (Freud, 1919). He anticipated that psychoanalysis would need to vary its technique to reach wider groups of people. His emphasis on flexibility supports the idea that adaptations to setting, culture, or circumstance can be legitimate ways of meeting young people where they are.

In practice, boundaries between supportive, psychodynamic and analytic work are often blurred, and many therapists adjust the level of interpretation according to patient and context. McLoughlin (2009) also highlights the pull in schools towards external aims such as preventing exclusion or supporting learning. These demands can obstruct symbolic work and push therapists towards more concrete approaches. At the same time, they are part of the context therapists must navigate, raising the question of whether such pressures necessarily dilute analytic work or simply test its flexibility.

Trevatt (2009) emphasises the potential of school-based psychotherapy for young people unlikely to access treatment otherwise. Although engagement can be challenging, the familiarity and rhythm of the school environment often make access easier and provide fertile ground for therapeutic work. The institutional context inevitably shapes transference – close contact with staff may evoke suspicion or persecutory anxieties, but it can also open new possibilities for engagement. Accessibility is especially important for adolescent boys, who are less likely than girls to access CAMHS, making school-based provision a potential lifeline. (Trevatt, 2009).

What emerges across these accounts is that schools generate their own transference dynamics, institutional pressures, and opportunities for engagement. These distinctive features mean the question is less about replicating clinic work wholesale and more about how analytic practice evolves in response to the school context.

2.5.4 Adaptation and Technique

Baruch (2001), drawing on his long-standing work at the Brandon Centre, argues that traditional clinic settings are often unappealing to adolescents, who may resist them as aligned with either children or adults. Separate, community-based services can symbolically fit better with the adolescent need for individuation and separateness. He stresses the need to adapt psychoanalytic technique for young people with serious difficulties who struggle in conventional therapy describing flexibility as an “enormous challenge” (p. 174) for clinicians trained within a structured frame. For Baruch (2001), engagement itself often becomes the central therapeutic task. Accessibility, he notes, depends as much on stance as on setting, with more supportive approaches predicting better retention, particularly for marginalised groups such as refugees, young offenders and young people with disabilities. Drawing on Luborsky’s (1976) account of the early “Type 1” alliance, he shows how therapists in community settings may need to take more responsibility at first -directing conversation, emphasising continuity, or arranging for others to bring the young person until regular attendance is established. Interventions may focus less on interpretation and more on building mental functions, linking feelings with actions, and supporting fragile ego capacities.

Emanuel (2016) describes the under-fives model in community contexts as a “a ‘slow unfolding at double speed’ (p.67), combining close observation with flexibility around frequency and duration. Interruptions, shared rooms and double bookings may become part of the material itself, expressing families’ anxieties about rivalry, displacement or exclusion.

Renschler (2009) highlights another form of adaptation through his discussion of “interpretation in action” (Ogden, 1994). In outreach, acts such as riding a bus with a parent, accepting food, or holding a baby can take on symbolic meaning when thought about psychoanalytically. His “sleeping on the couch” vignette illustrates the difference

between acting out and symbolic communication: the issue is not the act itself, but whether it is held and thought about within the transference.

Rogers (2014) adds a necessary ethical dimension. Writing about home-based psychotherapy, she warns that blurred boundaries, confidentiality and safety can test the frame when work moves outside the consulting room. Simple acts such as being offered food or witnessing family dynamics can carry symbolic meaning but also leave the therapist exposed. Without supervision and organisational containment, the frame can feel fragile and therapists risk burnout or enactment. Her reflections show that adapting the frame is never purely technical but also ethical, requiring containment not just for families but for therapists themselves.

2.5.5 Access, Culture and Inequality

Lowe (2010) highlights longstanding inequities in Black people's relationship with UK mental health services: admission rates are three to five times higher than for White populations, with compulsory detention more common and access to psychotherapy less likely (Healthcare Commission, 2008; Keating et al., 2002). These disparities, often linked to racism and inaccessible service cultures, are only one side of the barrier. Lowe (2010) also points to unconscious conflicts, fears of betraying family, culture or community with psychotherapy sometimes felt as a threat to identity or even as a new form of colonial intrusion.

In response, the Tavistock set up the Young Black People's Consultation Service, offering up to four consultations led by Black clinicians in both clinic and community settings. Young people's engagement was ambivalent: some did not attend, others doubted therapists could understand them, and even in clinical material defiance and distrust coexisted with longing for connection. This ambivalence was mirrored organisationally, where professionals questioned the need for a separate service (Lowe, 2010), echoing policy debates about race equality in mental health (Department of

Health, 2005). Linking these dynamics to the intergenerational trauma of slavery and racism, Lowe (2010) reframes access as shaped by both systemic exclusion and internalised defences, strengthening the case for outreach models that adapt the frame while working with, rather than against, ambivalence.

Bains (2001) also shows how culture and community shape both distress and engagement. At the Brandon Centre, around a quarter of young people seeking psychotherapy were from minority backgrounds, often carrying the added weight of racism, migration loss and disrupted networks. Help-seeking was shaped by cultural frameworks: for example, Chinese families sometimes expressed distress through somatic symptoms, while Ethiopian refugee families might understand difficulties in spiritual terms, seeking help from faith leaders or traditional healers (Bains, 2001). Within this context of institutional mistrust, therapists needed to be explicit about confidentiality and begin from a supportive stance. Recognising racism or validating cultural experience could turn mistrust into trust, after which analytic exploration became possible.

Research shows that Muslim families, refugees, asylum seekers, and Gypsy, Roma and Traveller communities remain underrepresented in CAMHS, with barriers shaped by language, stigma, faith identity and institutional mistrust (Dogra, 2013; Abedi, 2021). Adolescent boys are also less likely than girls to access CAMHS (Trevatt, 2009), and families from lower socioeconomic groups face the paradox of greater need but less access. These disparities highlight the need for outreach models that engage directly with cultural, faith and community contexts, rather than assuming clinic-based approaches alone can meet diverse needs.

Bargawi and O'Dwyer (2016) extend this discussion through baby clinic work with families from refugee, asylum-seeking and migrant backgrounds. Racism, migration loss and a lack of trust in institutions shaped whether families engaged at all.

Engagement was complicated further by unfamiliarity with psychological ideas and, at times, stigma around mental health. The authors stress the importance of exploring these dynamics without either minimising or over-emphasising cultural difference, echoing Andreou's (1999) call for curiosity about how distress relates both to family functioning and to wider cultural experience. Flexible responses such as offering an ad hoc appointment to a young mother could make the difference between withdrawal and contact. The baby clinic, as a familiar setting, reduced barriers while holding complex cultural meanings.

2.6 Recurring themes across settings and studies

Although the projects vary widely, some consistent threads help to answer the review's initial questions about how psychoanalytic work develops and survives outside the clinic. Across settings, engagement itself often becomes the main therapeutic task. Whether in schools, baby clinics, hostels, community centres or prisons, the first step is to make therapy possible and to stay with families who might otherwise never reach CAMHS.

Containment is another recurring theme, needed not only for children and families but also for staff and professionals. Supervision, team meetings and reflective spaces are described as essential, with organisational holding forming part of the clinical offer.

Another theme is the challenge of working psychoanalytically in places not built for it. Classrooms, reception centres, prisons and hostels were never designed with therapy in mind, yet clinicians have found ways to work within them without losing authenticity. This calls for balance: resisting institutional agendas while holding onto an analytic stance when settings push towards more concrete aims.

There is also a strong sense of creativity and persistence. Outreach relies on clinicians who can translate analytic ideas into everyday language, reach families who

may feel mistrustful, and use whatever space is available. A staff room (Jackson, 2009), a car park (Music, 2004), or a group on cushions in prison (Baradon & Target, 2008) all became viable settings when held psychoanalytically in mind.

Culture, identity and social context also shape the work. Lowe (2010) highlights how racism and mistrust of institutions affect whether Black families seek help, while Bains (2001) shows how cultural frameworks influence how distress is expressed and how families approach services. Projects with migrant, refugee and homeless families underline the need to acknowledge these contexts and adapt flexibly to reduce barriers. Writings by Twemlow (2013) on community psychoanalysis, and Kennard (2004) on therapeutic communities, echo these concerns, pointing to shared dilemmas of setting, adaptation and survival across the psychoanalytic field.

Policy and sustainability also recur. Many projects began in response to government priorities – delinquency, teenage pregnancy, migration, youth violence which gave them legitimacy but tied them to short funding cycles and narrow evaluation measures. Prevention is not only about targeted crisis interventions but about the presence of stable and ordinary therapeutic relationships over time.

2.7 Gaps in the literature

Despite the range of projects described the literature on psychoanalytic outreach remains limited. Most publications are clinical or reflective rather than empirical, and few include long-term follow-up or comparative evaluation. Existing studies are usually small and descriptive, tied to single projects, leaving little evidence about what helps outreach to last across time or contexts. It also appears that many services depend on individual clinicians or small teams who are personally committed to making them work. Their continuity may rely more on professional passion than on institutional or policy support, making outreach both creative and precarious.

The concentration of publications from the 1970s to the 1990s may also reflect a period of greater openness to experimentation, compared with the more cautious climate of recent years. Fewer recent papers have appeared, with the most up to date published in 2021. It may be that outreach has continued in practice but has been written about less, or that we now work in a more cautious climate where innovation is harder to sustain.

There are also gaps in the kinds of settings covered. Schools, clinics and some early years projects dominate, while far less is written about youth organisations, charities, faith groups, youth offending teams, community centres or prisons. Projects using other ways into engagement, through music, sport or the arts, are largely absent from psychoanalytic accounts, even though widely used in community mental health. When mentioned, these projects are often described with little detail about technique or practice.

Even where outreach services have gathered outcome data, it is not always visible in the literature. For example, the Brandon Centre (2001) initiated a randomised controlled trial comparing CBT with supportive counselling for young offenders, but I could not find results published – a missed opportunity for the field. More broadly, the literature rarely balances the two forms of writing most needed: detailed practitioner papers showing how psychoanalysis is adapted in community settings, and systematic studies that evaluate those adaptations. Both are needed if the field is to develop.

Less developed in the literature is discussion of how fragile policy-driven initiatives can be. Projects created in response to single government priorities are not, on their own, preventative. Prevention requires stable investment in both community initiatives and statutory services, so that help is available before crises. For families with histories of neglect or abuse, such stability itself can carry symbolic meaning, signalling that care is genuine rather than tokenistic. Outreach highlights the value of embedding

psychotherapists in ordinary settings, where support becomes part of everyday life rather than visible only at moments of breakdown. Yet the literature rarely explores how to sustain this beyond short-term policy initiatives.

The literature highlights both the creativity and the limits of psychoanalytic outreach. A recurring theme is integration, as clinicians embed in new settings while supporting children and families move towards greater internal integration. Yet several questions remain: how psychoanalytic work can be maintained across changing settings, what helps clinicians to sustain it over time, and what conditions make outreach possible and meaningful.

2.8 Conclusion and Recommendations

This review shows that psychoanalytic outreach has a longer and more varied history than its current visibility might suggest. Across schools, early years services, adolescent clinics and other community settings, clinicians have adapted the way the work is offered while continuing to think about unconscious communication, transference, containment, relationships and symbolic meaning. The literature makes a case for adaptation and suggests that the psychoanalytic quality of the work does not depend entirely on reproducing the same external frame in every setting. The room, frequency and boundaries remain important, but the clinician also has to consider what can be sustained within a particular context and what may need to change for contact to become possible.

The review also highlights how closely questions about adaptation are tied to professional identity. Shuttleworth's (1999) idea of "dual citizenship" captures the strain of holding on to psychoanalytic thinking while moving between different professional and institutional cultures, while Music (2004) describes the unease involved in leaving the consulting room and developing services in schools and with looked-after children.

Read alongside one another, these accounts suggest that hesitation around adaptation may not only concern technique. It may also reflect anxiety about whether something central to psychoanalytic identity will be lost when the work looks different or is carried into settings where it is less easily recognised. This raises questions about how strongly psychoanalytic practice has become associated with clinic-based work, and whether this can make more creative or community-based forms of practice feel less legitimate.

This tension is particularly important when considering access. Altman (2009, 2013) questions the assumption that the consulting room is a neutral setting, arguing that it has historically been more accessible to people who already have the resources, familiarity and confidence needed to use it. The literature raises questions about who may be excluded when one model of practice becomes closely associated with what counts as legitimate psychoanalytic work. Some children and families may be able to use regular individual sessions in a private room, while others may first need contact through a school, a group, an ordinary shared activity or a familiar community setting. This does not remove the need for a frame. It asks clinicians to think more carefully about how a frame is created, what makes it feel usable and how trust develops.

The historical literature is striking because it describes considerable experimentation from the late 1960s onwards, including walk-in clinics, adolescent services and work embedded in community institutions. There are fewer recent published accounts, although it remains unclear whether this reflects a reduction in outreach practice or whether such work has continued without being documented. This leaves a noticeable gap between the psychoanalytic knowledge developed through earlier community practice and its translation into contemporary services. It also raises questions about which forms of practice the profession has chosen to record, develop and learn from, and whether clinic-based work has remained more visible and established than community practice.

The literature also shows how fragile outreach projects can be. Many developed through the commitment of individual clinicians or small teams and were linked to short-term funding or particular policy priorities. This created opportunities for innovation, but often left the continuation of the work uncertain. For clinical practice, this suggests that outreach needs to be recognised as a serious and sustained part of psychoanalytic work, rather than something that depends mainly on individual interest and persistence. Clinical creativity alone cannot provide the conditions needed for outreach to survive. Practitioners require supervision, reflective spaces, supportive partnerships and organisations that understand the emotional and practical demands of the work. Flexibility should not automatically be understood as a loss of psychoanalytic depth, but requires careful thought about what needs to remain consistent and what can change in response to the setting. More stable investment is needed if community projects are to become embedded and offer a reliable presence, rather than disappearing when funding or policy priorities change. The review also suggests that community-based practice needs greater recognition within psychoanalytic training, supervision and professional writing, so that the learning developed through this work can be shared and built upon.

Future writing and research should continue to develop both sides of the evidence base. Detailed clinical accounts remain important because they can show how the frame, technique and psychoanalytic thinking are adapted in practice, particularly in settings that remain largely absent from the literature, such as faith organisations, youth groups, sport, arts projects, youth offending services, community centres and prisons.

These accounts should sit alongside more systematic research that follows projects over time, compares work across different settings, and examines who is reached, what supports engagement and what helps services continue. Outcome research may also be useful, particularly as the review found little published evidence of this

kind. However, it should sit alongside qualitative and clinical research that can explore changes that are harder to measure, including trust, relationships, symbolic thinking and the emotional life of the setting.

The review therefore leaves a number of questions open. It does not fully explain how contemporary CAPTs experience working across different outreach settings, how they decide what should remain consistent and what can be adapted, or how they understand what makes the work psychoanalytic. There is also limited research into the emotional and institutional conditions that allow these projects to develop and survive. These gaps provided the basis for the empirical study that follows, which explores how CAPTs describe their work across a range of community settings, what makes engagement possible, and what supports or threatens the continuation of psychoanalytic outreach.

3. Methodology

3.1 Introduction to the Empirical Study

The literature review described psychoanalytic outreach across schools, early years services, adolescent clinics and other community settings, including how clinicians adapted the frame while continuing to attend to unconscious communication, containment, transference and symbolic meaning. It also identified gaps in the contemporary literature, which remains largely focused on individual projects and offers limited insight into how CAPTs experience this work across different settings, what informs the adaptations they make, and what supports or threatens its continuation. In response to these gaps, the empirical study aimed to explore how CAPTs understand and carry out psychoanalytic work in outreach settings. A qualitative approach was chosen because the study was concerned with clinicians' experiences and the meanings they gave to their work, including the decisions, tensions and complexities involved. It allowed patterns to be explored across different projects while remaining close to the detail of participants' accounts.

The study was guided by the following overarching research question:

How do Child and Adolescent Psychotherapists work psychoanalytically in outreach settings?

The following related questions reflected the aims of the research:

1. What leads CAPTs to develop outreach projects, and what barriers to accessing clinic-based CAMHS services are they seeking to address?

2. How do CAPTs adapt psychoanalytic thinking, the therapeutic frame, their role and the therapeutic offer across different community settings, and how do they work with the communities and organisations in which the projects are based?
3. What benefits, challenges and limitations do CAPTs identify, and what makes outreach possible, meaningful and sustainable?

3.2 Design and Rationale

This study used a qualitative design to explore the experiences of Child and Adolescent Psychotherapists working in outreach. I carried out semi-structured interviews with four clinicians, all of whom were lead clinicians or founders of psychoanalytically informed outreach projects. The interviews were analysed using Reflexive Thematic Analysis (Braun & Clarke, 2006, 2021).

The study was designed through a psychoanalytic lens, attentive to unconscious meaning and relational process. Psychoanalytic research and clinical work have long been understood as interdependent. As Midgley (2006) notes, quoting Freud (1927, p. 256), there exists “an inseparable bond between cure and research.” Psychoanalysis offers not an alternative to science but its own model of disciplined observation and theory-building (Rustin, 2019), a science of subjectivity (Leuzinger-Bohleber, in Hinshelwood, 2013) concerned with what can be known through lived and relational experience rather than objective measurement. Hinshelwood’s (2013) observation that “the instrument for making observations of the human mind is another human mind” (p. 99) resonates with reflexive qualitative practice and the interpretive stance required in RTA, both of which recognise the researcher’s subjectivity as a vital tool of inquiry.

Rustin (2019) also describes psychoanalysis as a discipline that explores the “limits of certainty,” seeking meaning where full knowledge is impossible. This perspective sits within a constructionist and interpretivist epistemology, in which knowledge is co-created through interaction. The Association of Child Psychotherapists

(ACP, 2021) review similarly highlights that contemporary psychoanalytic research encompasses plural methods, including qualitative designs that retain sensitivity to unconscious communication and relational complexity. Positioning this study within that tradition allowed me to bring psychoanalytic attention to meaning, containment and projection into a systematic qualitative framework.

I chose a qualitative approach because I wanted to explore clinicians' experiences in depth and capture the complexity of their work in outreach. RTA offered a theoretically flexible framework for “developing, analysing, and interpreting patterns across a qualitative data set” (Braun & Clarke, 2021, p. 4), while staying close to meaning. It provided scope to consider both what was said and what was implied, allowing space for emotional and symbolic layers within participants' accounts.

An important part of this approach is recognising that the researcher is not separate from the process but an active and reflexive contributor to it. My subjectivity, reflections, and how I related to the data were part of how the analysis was made, rather than something to avoid. For instance, when I felt drawn to reassure a participant or align with their pride in the work, this awareness later helped me think about how idealisation might shape both the data and my interpretation. This position can feel at odds with the wish for objectivity, but within RTA it is seen as essential.

The analytic stance adopted here follows Braun and Clarke's wider work on reflexivity and interpretation (Braun & Clarke, 2006, 2013, 2019, 2020, 2021; Byrne, 2021). Byrne's worked example was particularly helpful in modelling how meaning evolves recursively through close engagement with data. RTA's emphasis on theoretical flexibility and interpretive depth fits naturally with psychoanalytic thinking, which also assumes that there are layers of meaning, including unconscious ones. Both approaches invite openness to uncertainty and to the emotional resonance of the material.

Other approaches such as Interpretative Phenomenological Analysis (IPA) or Grounded Theory were considered but ultimately set aside. IPA's idiographic focus works well with small, homogenous samples, capturing individual lived experience in depth (Smith, Flowers & Larkin, 2009), but my interest lay in identifying patterns across diverse outreach projects. Grounded Theory (Charmaz, 2014) is oriented toward generating new theory from data; my aim was not to construct a formal theory but to understand how clinicians make sense of psychoanalytic work outside CAMHS.

RTA fitted the psychoanalytic orientation of this study, offering a framework that could hold both conscious and unconscious meaning. It allowed movement between semantic codes (surface meaning) and latent codes (underlying or implied meaning), attending to tone, affect, and atmosphere as integral to interpretation. Reflexivity became a psychoanalytic practice in its own right: a means of recognising countertransference, projection, and the pull to idealise or defend. Meaning making was treated as a relational act, consistent with both psychoanalytic method and reflexive thematic analysis.

3.3 Research Setting and Context

The research involved interviews with clinicians working across a range of community based outreach contexts, including early years, school and sports projects, arts-based initiatives, and faith or community settings. The interviews were not conducted within these settings, keeping the focus on clinicians' reflections rather than direct observation. Participants could choose between in-person or online formats; three interviews took place online and one at the Tavistock and Portman NHS Foundation Trust.

Each participant was interviewed once. The interviews were long enough to allow for reflection and emotional depth but brief enough to hold the material within a contained frame. This design offered an intensive, in-depth encounter rather than a longitudinal view. While follow-up interviews might have allowed ideas to evolve over

time, single interviews preserved immediacy and reduced the burden on participants. This balance between depth and continuity reflects a common tension in qualitative work: what is gained in focus and containment may limit opportunities to trace change.

3.4 Participants

The final sample included four qualified psychotherapists. One was male and three were female, with between 5 and 25 years of experience. All were lead clinicians of their projects, and two were also founders. Each brought experience of working in a different model of outreach, with significant experience of both CAMHS and community work.

Their projects worked with a broad range of children and young people, from early years to adolescence. This included younger children in nursery provision, adolescents linked to school or sports projects, young people involved in a youth theatre, and families connected with a mosque and community centres. Together, their accounts offered varied perspectives on how psychoanalytic work is adapted in diverse outreach contexts.

Because this is a small professional community, there was some risk that even with pseudonyms and anonymised detail, participants might be recognisable to colleagues. This was explained to participants, and informed consent was obtained on that basis.

3.5 Inclusion and Exclusion Criteria

Eligibility was assessed in relation to both the participant and the outreach project they represented. All relevant participant and project inclusion criteria had to be met.

Table 4

Participant and Project Inclusion Criteria

Category	Criterion	Definition
Participant	Professional qualification	The participant had to be a qualified psychotherapist registered with the Association of Child Psychotherapists (ACP) or the British Association for Counselling and Psychotherapy (BACP).
Participant	Role within the project	The participant had to be the founder or lead clinician of the project and therefore able to speak about its development, therapeutic approach and delivery.
Project	Location	The project had to be based in the UK.
Project	Status	The project could be active at the time of recruitment or could have ended. Completed projects were eligible because the study also sought reflections on how outreach work developed and was sustained over time.
Project	Population	The project had to work with children or young people aged 3–25. Work with parents or professional networks was eligible where it formed part of an intervention concerned with the child or young person.
Project	Setting	The intervention had to take place beyond a traditional clinic-based CAMHS setting, in line with the working definition of outreach used in

		this thesis. This included educational, faith, arts, voluntary-sector and other community settings.
Project	Theoretical orientation	The project had to be explicitly informed by psychoanalytic or psychodynamic thinking. The participant was asked during the interview to explain what made the work psychoanalytic or psychodynamic.
Project	Form of intervention	Brief, long-term and drop-in interventions were eligible. The work could involve direct psychotherapy, consultation or work discussion, provided that it formed part of the psychoanalytically or psychodynamically informed outreach project.

The way a project was commissioned or funded was not used to determine eligibility. Projects could therefore be NHS-funded, linked to CAMHS, independently funded or based within charitable or voluntary-sector organisations

Table 5

Participant and Project Exclusion Criteria

Category	Criterion	Definition
Participant	Professional qualification	Practitioners who were not qualified and registered with the ACP or BACP were excluded.

Participant	Role within the project	Practitioners who were neither the founder nor the lead clinician of the project were excluded.
Participant	Existing evaluative relationship	Practitioners who were known assessors involved in my doctoral training were excluded to avoid an existing evaluative relationship.
Project	Location	Projects based outside the UK were excluded.
Project	Population	Projects that did not work with children or young people aged 3–25, either directly or through work connected to them, were excluded.
Project	Setting	Projects delivered solely within a traditional clinic-based CAMHS setting, with no outreach or community-based element, were excluded.
Project	Theoretical orientation	Projects that were not explicitly informed by psychoanalytic or psychodynamic thinking were excluded.
Project	Form of intervention	Projects offering only non-therapeutic activity or general support, with no psychoanalytically or psychodynamically informed therapeutic work, consultation or work discussion, were excluded.

3.6 Recruitment and Sampling

This was a small, opportunistic sample. I had initially aimed to recruit five to six participants, but despite advertising through ACP, direct approaches, and online searches (including LinkedIn), uptake was limited. One participant withdrew, leaving a final group of four.

Participants were recruited in different ways: one responded to the ACP advert, one came through word of mouth, and two were contacted directly after I heard about their projects and reached out by email. When approaching participants, I sent an information pack (see Appendix) which included details about the study, what taking part would involve. Signed consent forms were obtained before interviews.

Interviews were offered either in person or online to accommodate busy clinical schedules. The projects represented diverse contexts: an early year's provision, a school-based project using football, a youth theatre, and a community initiative centred around a mosque.

All participants were experienced clinicians who had played a leading role in developing their projects – three as founders and one as long-term lead. Their depth of experience brought authority to the material but also required reflexive awareness. Having volunteered to take part, they were a particularly motivated group, proud of the work they had built. This enthusiasm gave access to the vision and values that sustain outreach but may also have made it harder to speak about difficulty or doubt. I tried to hold both possibilities in mind, thinking about how identification and protectiveness might enter the dialogue and what this conveyed about the place of outreach within the wider discipline.

3.7 Data Collection

Interviews were semi-structured and lasted between 60 and 90 minutes. Three were conducted on Microsoft Teams and one in person at the Tavistock and Portman NHS Foundation Trust. I took brief notes during and after each interview.

The schedule included open questions about participants' motivations for outreach, the challenges and benefits of the work, and how psychoanalytic thinking shaped their practice. The full schedule is provided in the Appendix. All interviews were audio- and video-recorded, transcribed verbatim, and anonymised during transcription.

3.8 Data Analysis

The analysis followed Braun and Clarke's (2006, 2021) six phases of RTA. I approached the data inductively, with flexibility and reflexivity, while drawing on a psychoanalytic framework to attend to underlying meaning. The process was recursive rather than linear.

I treated participants' accounts and feelings as windows into their lived experience of outreach work, while also attending to what might be implied or unconscious. In practice, this meant coding both semantic content and latent aspects that reflected underlying processes or assumptions. Some of the more psychoanalytic interpretations were carried forward into the Discussion, where they could be connected to the literature and explored in greater depth.

3.8.1 Phase 1: Familiarisation with the data

I immersed myself in the transcripts by listening, watching, transcribing, and writing summaries. I personally transcribed all four interviews, using Teams and Otter auto transcriptions as a base, then carefully corrected them against the audio. I chose to retain repetitions, pauses, and some utterances to preserve the feel of participants' accounts unless this affected readability. I also watched video recordings, as facial expressions

and tone were vital in grasping meaning. Tone and affect often conveyed as much meaning as words. In one interview, the firmness in a participant's voice gave me a palpable sense of what it might be like to hold boundaries close to danger – an embodied experience that deepened my understanding of the emotional reality of the work and shaped how I later attended to tone and atmosphere.

To deepen familiarisation, I wrote page-by-page summaries of transcripts, noting early impressions, countertransference responses, and emerging questions. This iterative process helped me hold both the detail and the overall emotional texture of each interview.

3.8.2 Phase 2: Generating Initial Codes

Across the four transcripts, I generated 1,146 codes in two to three sweeps per interview. Early sweeps produced descriptive, semantic codes; later sweeps were more interpretive, producing latent codes that drew on cultural context, psychoanalytic thinking, and implicit meaning.

Coding was initially done in Word using comments, then extracted into Excel for review. I aimed to phrase codes so they could stand alone while staying close to participants' language. Throughout, I wrote reflective notes, capturing moments when my own assumptions or countertransference responses shaped what I heard. Coding felt like a rhythm of zooming in line-by-line and zooming out to hold the interview as a whole.

I resisted assuming what the themes would be, allowing codes to capture meaning without forcing early patterns. Codes were reused across interviews only when they naturally fit.

3.8.3 Phase 3: Generating Themes

Once coding was complete, I began grouping codes provisionally – a lengthy and iterative stage. I reviewed codes in Excel but also worked manually, cutting and arranging them on paper to test groupings. At one stage, 62 provisional categories felt overwhelming; these were gradually refined by merging duplicates, renaming, or deleting those not aligned with the research question. Overlaps such as Holding the Frame and Boundaries were combined, while others were reframed, such as Measuring Success evolving into Indicators of Progress. New areas, like Therapist Role and Identity, also emerged, capturing repeated references to language, clothing, and power.

I created mind maps and asked, “What is the story here?” to clarify the analytic narrative amid the volume of material.

3.8.4 Phase 4: Reviewing Potential Themes

I refined categories further using colour-coding in Excel to check fit and highlight overlaps. When uncertain, I temporarily placed codes in two categories and returned later with fresh perspective. Outliers were reviewed carefully to decide whether to reallocate or discard them. At times this meant moving codes across categories or renaming categories so they could stand alone more clearly.

I revisited the research questions when the data seemed to pull towards broader systemic issues such as CAMHS structures or training. These provided context but had to be filtered so the analysis stayed true to the study’s focus.

3.8.5 Phase 5: Defining and Naming Themes

As refinement continued, I focused on each theme’s boundaries and meaning. To prevent overwhelm, I grouped related areas into temporary clusters – a way to test higher-level patterns before committing to a final structure. This helped link scattered codes, for instance, showing how cultural context intersected with access and trust. I

then clarified theme boundaries and phrasing, guided by Braun and Clarke's (2012) questions: Is this really a theme or just a code? What are its limits? Is it coherent and meaningful?

Some overlaps required judgment – for instance, work with parents and networks belonged more in Emotional Texture of the Work than in The Psychoanalytic Offer. This reflects how, in RTA, theme boundaries are negotiated rather than fixed. I also considered balance across outreach settings, showing both variation and shared threads without distorting the analytic story.

By this stage, the 62 provisional categories had been refined to 19 subthemes within six overarching themes.

3.8.6 Phase 6: Producing the Report

In the final stage, I prepared short summaries of each theme, using codes and extracts to build a thematic map and analytic narrative. Themes are presented in the Findings chapter as interpretive stories rather than simple topic summaries, in line with Braun and Clarke's guidance.

3.9 How the Psychoanalytic Framework Informed the Analysis

Looking back across the six phases, the psychoanalytic framework was most present in the way I listened to and thought about the material. When I listened again to each interview and wrote page-by-page notes, this felt similar to writing and reviewing clinical process notes. I followed the detail of what was said while also noting my impressions, the emotional atmosphere and what the material evoked in me. These notes became part of the meaning-making process. Rather than treating my emotional responses as evidence, I used them to ask further questions about whether a feeling seemed to belong mainly to me, to the participant, or to something created between us

during the interview. This allowed me to use countertransference as a source of enquiry while remaining critical about my own contribution.

One example arose when a participant spoke about holding firm boundaries in work with young people affected by serious youth violence. Their firmness initially felt harsh and made me uncomfortable. Listening again and returning to my notes helped me think beyond this first response. Through a psychoanalytic framework, I began to understand the firmness as potentially communicating a paternal function, offering structure and protection in work where danger and chaos were close. This interpretation did not replace what the participant had said. Instead, it led me back to the transcript to consider how boundaries, risk and containment were described across the interview and elsewhere in the data. In this way, psychoanalytic thinking helped me move from an immediate emotional response towards a more considered interpretation.

I was also aware that I felt more connected to some interviews, particularly when participants described experiences or views that closely reflected my own. This created a risk that I might give greater weight to material that confirmed my existing beliefs about outreach. Repeated coding sweeps and returning to participants' words helped me question whether I was staying close to their accounts or selecting material that supported the argument I hoped to make. The analysis also continued during the process of writing. Through supervision, I became more aware of how splitting and idealisation had shaped parts of my interpretation, positioning outreach and CAMHS as opposing positions and placing greater emphasis on the limitations of clinic-based services. This led me to revise parts of the discussion and to recognise more clearly how participants described the two forms of provision as connected and, at times, mutually dependent.

3.10 Reflexivity

Throughout the analysis I engaged in reflexive practice, noting assumptions, biases, and emotional responses. At times I worried about “coding too much” or being pulled by my own values about outreach. I used journaling to reflect on these pulls and to consider how my training and experience shaped what I attended to. The process of coding also changed as I moved through the transcripts. By the later transcripts, I had more confidence and a working set of codes, which may have affected what I noticed compared with the first. I therefore returned to all four transcripts as my thinking developed, considering whether I had missed or given too much weight to particular material. In keeping with RTA, I understood the findings as produced through my engagement with participants and the data, rather than as a neutral account waiting to be discovered.

During interviews, I noticed a pull to reassure participants when they seemed anxious or self-critical, or to present outreach positively. I became aware that this may have shaped the interview process, including how far I challenged participants or followed up tensions within their accounts. Holding this in mind helped me recognise that the data were produced through the interaction between us, rather than simply collected from participants.

For instance, in one interview, a participant contrasted a child in Hampstead with the young people in their project, evoking an unspoken picture of who psychoanalysis reaches. It implied a distinction between the concerns of Hampstead children, perceived as perhaps more psychological or contained, and the deprivation and risks faced by those growing up in other parts of London. The contrast added texture to how I understood the emotional landscape of outreach, but it also brought up thoughts about belonging and legitimacy, including who and what counts as psychoanalytic. Reflecting on this made me more alert in the analysis to how ideas of class, place and identity

shape both access to therapy and how different kinds of psychoanalytic work are understood and valued.

3.11 Trustworthiness

Quality in qualitative research is not measured through reliability in the quantitative sense but through credibility, transparency, reflexivity, and transferability (Braun & Clarke, 2021; Noble & Smith, 2015). In psychoanalytic research, rigour is similarly judged by transparency, coherence, and depth rather than replication (Midgley, 2006; ACP, 2021). Making analytic reasoning visible, as RTA demands, parallels the psychoanalytic commitment to bringing unconscious processes into thought.

To uphold these principles:

- **Credibility:** I grounded interpretations in participants' words, illustrating themes with extracts in the Findings chapter. I regularly returned to the transcripts to check that my interpretations stayed close to the material.
- **Transparency:** I kept a detailed record of the analytic process, using Excel spreadsheets to track codes and changes across stages. I also kept handwritten notes and mind maps to capture decisions about merging or renaming categories, returning repeatedly to the data from different angles.
- **Reflexivity:** I noted my assumptions, biases, and countertransference responses. Supervision provided a space to think about these pulls and to remain open to complexity rather than neatening the data too soon.

Transferability: The findings are not generalisable but may resonate in other contexts where psychoanalytic work is adapted for outreach. Detailed description allows readers to decide whether the findings might apply to their own practice.

3.12 Ethical Considerations

Ethical approval was granted by the Tavistock and Portman NHS Foundation Trust Research Ethics Committee (TREC) in January 2024 (see Appendix C) and was sponsored by the Tavistock and Portman NHS Foundation Trust.

All participants received an information pack and gave signed informed consent before interviews. The pack outlined confidentiality, data storage, right to withdraw, and safeguarding. A debrief form was provided, including details of NHS counselling services and contact information for me, my supervisor, and academic governance should any concerns arise.

Confidentiality was upheld by anonymising transcripts and presenting descriptions in broad terms. However, given the small professional community, participants may still be recognisable to colleagues; this was explained, and consent was sought on that basis. Data was processed in line with GDPR and the Data Protection Act (2018).

4. Findings

The interviews were analysed using reflexive thematic analysis. From this process I generated 1,146 codes, which I refined into six overarching themes and 19 subthemes. Table 1 provides an overview of the six themes and their subthemes; with brief descriptions of the analytic story each theme tells.

The themes are presented in the following sections, with subheadings to bring out different aspects of each theme. Extracts from the interviews are included alongside my interpretation, to stay close to participants' voices while drawing out the analytic story. Participants are referred to by number (e.g. P1, P2). The four outreach services are described in anonymised form to protect confidentiality, while still giving a sense of their settings and contexts.

In line with Braun and Clarke's (2021) approach to reflexive thematic analysis, the aim is to create a narrative with the data rather than to catalogue every code. Extracts were chosen because they best illustrate the themes and convey the emotional and symbolic texture of the work. The themes are presented in a narrative order that reflects how participants described the unfolding story of outreach – from the motivations that made it necessary, to how psychoanalytic work was adapted, lived, sustained, and understood in practice. Together, they address all five aims of the study, though not in the same sequence.

Table 6

Overview of Themes and Subthemes

Theme	Subthemes	Brief description of theme
4. 1. Why Outreach?	4.1.1 Motivations for Outreach 4.1.2 Barriers to Access 4.1.3 Reframing Disengagement 4.1.4 Referral Processes in Outreach 4.1.5 The Role of the Setting 4.1.6 Cultural and Community Context	Explores why therapists are drawn to outreach, and how it responds to mistrust, exclusion, and cultural context to make therapy possible.
4.2. The Psychoanalytic Offer, Redefined	4.2.1 The Therapeutic Offer 4.2.2 Boundaries and Holding the Frame 4.2.3 Therapist Role and Identity	Shows how psychoanalytic practice is adapted outside the clinic, including how the frame and therapist role are redefined.
4.3. The Emotional Texture of the Work	4.3.1 Relational Work and Containment 4.3.2 The Emotional Demands and Impact of the Work 4.3.3 Parents and Networks 4.3.4 The Power of the Ordinary	Describes the relational and emotional qualities of outreach, the demands on therapists, and the importance of ordinary forms of contact.
4.4. Making it Work in Practice	4.4.1 Flexibility and Adaptation 4.4.2 Working in Partnership and Collaboration 4.4.3 Holding Risk and Safeguarding 4.4.4 Challenges and Limitations of Outreach	Focuses on the practical realities of sustaining outreach work, including adaptation, collaboration, and facing risks.
4.5. CAMHS vs Outreach: Two Different Worlds?	4.5.1 Contrasting Models and Expectations 4.5.2 Bridging and Working Across Settings	Highlights differences between CAMHS and outreach, and how outreach can act as a bridge across systems.

4.6. Indicators of Progress	(no subthemes)	Looks at how progress is understood in outreach, often through subtle, symbolic or relational shifts.
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4.1 Why outreach

4.1.1 Motivations for Outreach

Participants spoke about strong personal and professional motivations for undertaking outreach work. For some, it reflected a longstanding pull to be alongside young people and a belief in the transformative power of the right kind of support. Outreach felt like an active response to suffering that otherwise might be endured in silence.

Some participants traced their motivation back to life experiences:

I hated school. I hardly went, so I know what it's about...that's the whole reason I set it up, because it was like, okay, sitting in a room in the silence with a 13-yearold that's never spoken to his parents, who's involved in gang activity – what do you think is gonna happen? You'll be lucky if you get a punch in the mouth. This is a different approach... let's just chat...and then you can start to control it, and then you can start to move. (P3).

For him, there was a direct parallel between his own history of shutting down at school and the approach he now used with young people on the brink of exclusion. What could feel rigid in a clinic became more fluid and possible in the young person's world, where sport and activity created an opening for conversation and movement.

Personal identity also shaped motivation. Some participants felt their own backgrounds sharpened their awareness of gaps in provision. One spoke of noticing that Muslim young people were almost entirely missing from services and felt compelled to act. Outreach was described as a way of making therapy visible in spaces where trust already lived.

One participant spoke of being moved by encounters that carried life and death significance. Outreach was not abstract but urgent work with young people caught in precarious positions – entangled in gangs, criminal exploitation, or cycles of violence. Participant 2 described moments of being pulled into this reality:

this young man ...he never explicitly said he was a drug dealer, but my thinking was he was hustling, and so he was very much on the edge, and he would have never come into a service ever. It was a most extraordinary feeling in the room with him looking at the door, twitching at every noise. Then suddenly he said, 'I want a normal job,' and cried. After that he came every week, exactly on time...even at 9am, he was there.

Moments like this captured what drew participants into outreach, the sense that the need was there, and that therapy could become possible when offered in ways young people could actually take up. For some participants, this way of working was described as almost instinctive: "I don't know if it's a specialism or not, but I seem to be able to work with young people who find it hard to access more traditional interventions" (P3).

Participants spoke of a grassroots impulse to reach those absent from CAMHS, children excluded from school, facing discrimination or deprivation and to create new ways of contact. Two participants emphasised that outreach made therapeutic help accessible to young people whose externalising behaviours, or involvement in criminality, would make them unlikely to enter a clinic. Part of this was about the meaning attached to services themselves. Some carried a negative transference to

services, experiencing them as stigmatising. Outreach could cut through this, offering contact in spaces that felt less shaming and more possible to approach.

There was also a more collective motivation: to challenge rigid ideas of what counts as ‘proper’ therapy. “People thought proper psychotherapy was five times a week in a clinic...do we want our profession to just sit there, or do we want to make sure it’s accessible?” (P1).

Outreach was experienced as a way of keeping therapeutic values intact while loosening the structures that exclude.

4.1.2 Barriers to Access

Participants highlighted a wide range of barriers preventing young people and families from accessing CAMHS. These were not only practical difficulties but structural ones, rooted in mistrust, cultural blind spots, systemic prejudice, and entrenched inequalities. Outreach was often described as a way of recognising and responding to these obstacles rather than expecting families to overcome them alone.

For some young people, racialised experiences with statutory services created a deep reluctance to seek help from the police or other authorities. Instead, they turned to trusted figures in their community:

Because they're black and because of their experience with the police, they would no way call the police... a young man found his brother dead, he wasn't going to call the police... he called the [founders], and then they sort out the services. (P2).

Here, the intervention acted as a lifeline in crisis, offering a route to support when mainstream systems were perceived as unsafe. It spoke to the trust placed in community figures, and how outreach relied on alternative networks when official services had been cut off by fear.

Fear and mistrust of services were also common among families. One therapist working in a nursery observed:

Most of the families don't trust authority figures... so-called experts [or] clinics. They're terrified of children's services because they believe they have the power to remove children. It's only when they realise their child enjoys the nursery... they can trust, and then they can come and see me. (P4).

Mistrust was grounded in lived histories of disappointment and institutional threat, often within single parent households where parents themselves had been let down. Outreach here was not simply about moving therapy into another building but about building trust through the ordinary rhythms of nursery life. The therapist described softening her professional stance to avoid reinforcing the distance between authority and accessibility.

Faith identity and culture were also described as central but often overlooked by statutory services. Participants spoke of the underrepresentation of Muslim families in CAMHS referrals and the lack of curiosity about faith identity in assessments and records. The absence of recognition was felt as a significant barrier, reinforcing families' worries that their values might be dismissed or pathologised. Outreach services sought to counter this by being visibly embedded in communities and by paying close attention to the ways faith and culture shape young people's lives.

Some families described a double pressure of silence, caught between fears of judgement from outside and the difficulties of speaking openly within their own communities:

Someone said, I haven't told anyone in my community about this problem I had with my child, because it's so difficult to talk within the community about certain things, and it's so difficult to talk to anyone outside because of the fear of prejudice. (P1).

This showed how barriers were not only structural but emotional and cultural, shaping what could be shared and with whom. Stigma around mental health also shaped access.

In some communities, even the words “mental health” and “therapy” carried negative connotations, making families reluctant to engage. Therapists described adapting their language, offering “emotional wellbeing sessions” rather than “therapy,” to make the offer feel ordinary and safe. This was not about disguising therapy but reducing the stigma so that support could be taken up.

Therapists also pointed to the wider backdrop of deprivation and inequality, describing children’s struggles as bound up with long-standing, intergenerational difficulties rather than isolated problems.

4.1.3 Reframing Disengagement

Participants described how disengagement is often misunderstood in mainstream services as failure or non-compliance. Where DNAs in CAMHS might be read as a lack of motivation, disengagement in outreach was expected and understood as part of the work. It was seen less as avoidance than as communication, a way of testing whether the therapist and the frame could bear uncertainty, absence, and ambivalence.

Some of the systemic roots of disengagement were highlighted. Services often rely on a developmental idea of “readiness,” which means young people excluded from school or presenting with externalising behaviour are quickly positioned as “not ready.” Participant 3 reflected on how exclusion from school can carry the sting of rejection: schools hold something of a parental function, so being placed “over there” in a PRU felt like being taken out of the family. From this perspective it was unsurprising that other institutions, including therapy, were met with caution, and that attendance in the sometimes inconsistent.

Participants also reflected that access was not only logistical but emotional, depending on how open the therapist allowed themselves to be. One P1 explained: “It’s

not just access into referrals; it's access to someone's mind...are we open as a therapist; do they have access to our mind?"

This emphasis on therapist openness placed responsibility on the professional as much as on the young person, framing engagement as a two-way process. It also echoed a psychoanalytic stance: that absence, silence, and ambivalence are part of the transference and need to be worked with rather than defended against.

Outreach services responded by holding a different stance towards absence. Rather than assuming a lack of motivation, participants stressed the importance of seeing disengagement as communication. Participant 1 explained:

We were aware that, because of the complexity of the cases, we need to really make the extra effort to have contact with the young person. They might not show up. If they don't show up for three weeks, it's not like... that's it, next. We keep on trying to keep the contact, because it takes time for the young person to trust that we're going to be there.

Persistence was central to building trust. Keeping the young person in mind, even when they did not turn up, showed they had not been dropped. For those who had often been let down, this was what made it possible to start trusting.

4.1.4 Referral processes in outreach

Referrals in outreach settings often happened through everyday relationships, not formal systems. Therapists described how families found their way in through trusted people; nursery staff, youth workers, siblings, or by seeing the therapist around and feeling something was possible.

Referrals came from many places – early help, social care, schools, GPs, refugee charities, or adult counselling services in the same setting. Some used referral forms adapted for different settings while others made space for young people to self-refer or drop in informally: “the more they hear that it's there, we get referrals.” (P1).

In the nursery setting, referrals did not depend on thresholds. “Often the reason for referral will be my child doesn't listen to me...usually when I start to meet with the parent, I realise that is the tip of the iceberg of a much bigger problem.” (P4). Everyday worries often signalled deeper emotional needs, so therapists paid attention not only to what was brought but also to what lay underneath.

In other projects, referral criteria were clearer but still held flexibly. One focused on boys at risk of exclusion, yet others gravitated towards it. Initially, the project operated a referral only model, but this gradually evolved to meet a growing interest: “Initially, we worked with 20 children. I opened it up. We were getting 40/50.” (P3).

Formal referrals created a base, but young people also arrived through friends, curiosity, or word of mouth. The instinctive foresight to ‘open it up’ reflected a deeper belief in inclusion over exclusion, that if young people were seeking out the space, they probably needed to be there.

Some projects used informal triage systems to protect therapists. Staff could raise concerns, but the therapist decided whether to take things forward: “There is a sort of triage system so that not everybody can just refer to me, otherwise I would be overwhelmed.” (P4). Across the settings, consent and referral forms were handled gently. Families needed time to build trust before sharing details like GP or school contacts: “[Families] might be unsure what your involvement might mean for them, so just take it step by step.” (P1).

Some young people referred themselves after seeing the therapist around or being encouraged by someone they trusted. Presentations varied, behavioural struggles, trauma, loss, or more subtle worries but most were navigating a lot at once. Therapists paid attention to referral routes and to what they revealed about who was being reached, and who was not. Referrals often began through flexibility and relationship negotiated

informally at first but managed carefully so the practical requirements of the work were not left behind.

4.1.5 The Role of the Setting

Across all projects, the physical and relational setting played a central role in shaping how therapy was accessed, experienced, and sustained. Being embedded in trusted, familiar environments reduced barriers and made therapeutic work feel more possible, especially for young people and families wary of formal services.

Therapists spoke about the power of being where young people already were. Being based in the community removed practical obstacles, but also deeper layers of mistrust: “I think that the powerful thing about being in the community, for me is that you are where the young people are. They haven't got to go into a building...for this group of young people, who’ve had terrible racism and abuse, why the hell would they trust an institution?”(P2).

The setting carried emotional as well as practical significance. One participant working in a mosque (P1) described how connection sometimes came in the simplest of ways:

They might feel that they can't speak enough English to say something to me. But if we're sitting on the floor in the mosque...their child is doing cartwheels behind, somehow there's a way of connecting...these are people with terribly difficult experiences...it's so important to find a place that for them is accessible, and you can connect.

This shows how trust could build slowly through consistent, ordinary contact, even when trauma or language might otherwise have blocked it. In such moments, the setting itself seemed to hold pain that words struggled to carry.

Familiar, accessible environments also helped build trust with parents. In the nursery setting, being present at drop-off and pick-up times allowed therapists to

observe children but also to become part of the everyday landscape: "Parents see me around...I think they see me as part of the staff team and sort of part of the package of support...their trust in the nursery gets transferred to me."(P4).

For others, the setting shaped both transference and distance. While some found containment in familiar spaces "Some people prefer that idea that they're going to go completely outside and away from the community. They might well prefer that...but it's been important that the clinical work is coming from within."(P1).

Being embedded in a setting made it possible to respond to both kinds of needs. Therapists were seen around, not just in sessions, and their presence became familiar and less frightening. Participant 1 described how therapy felt different when offered from within a community rather than imposed from outside: "That will create certain kinds of transferences, but it's more than just the building. The frame is much more than the physical setting."

Participant 2 described how the setting itself recreated a family-like environment, with food provided each week. Young people came back after school or college, sat together, and were fed: "This is what we do. We are a family for these youngsters who don't have such a reliable network outside"

Here, setting and culture were not add-ons to therapy but part of it. The setting held the frame, shaped the atmosphere, and illuminated aspects of young people's inner worlds that might not have emerged elsewhere. This was also true in a school-based project, where links between the football pitch and classroom allowed therapeutic ideas to be transferred through action and reflection: "The more they were able to work on the pitch, the more they were able to work off the pitch...the setting made that linking possible." (P3).

For some young people, being met in a faith-based setting allowed other parts of themselves to be safely held, making space for difficult conversations: "Some came and

talked about their sexuality, which surprised me. I thought they wouldn't trust a religious-looking setting and a therapist with a headscarf. But they knew that part of them was safe, so they could bring the things that were really troubling them."

Across these accounts, the setting itself was part of the therapeutic offer. When young people were met in places where they already belonged, therapy did not need to be translated or explained. It could simply begin.

4.1.6 Cultural and Community Context

The data showed that outreach therapy could not be separated from the cultural and community contexts in which it took place. These contexts are interwoven with trust, belonging, and identity, shaping the very terms on which therapy is possible. Families bring histories of prejudice, deprivation, and judgement shaping what can be shared. For many, Islamophobia and racialised bias were lived realities, leaving families wary of how much of themselves they dared to show.

Trust was built not only with the therapist but with the setting itself. The familiarity of a nursery, youth group, mosque, or community project helped therapy feel safer. Participant 2, described how a Black-led project founded by two men with experience of prison created a culture of acceptance: "They've had a very difficult time, and they were the ones, 18 years ago, who thought this is not going to happen to other young people...there's no shadow cast, young people are just accepted." Here, the community's history and leadership were inseparable from the therapeutic frame, embodying resilience and belonging.

Sometimes cultural perspectives highlighted how easily things could be misunderstood. One therapist noted that even the idea of a 'lifespan' differs, for some faith backgrounds, life continues beyond death into judgement and afterlife, which can show up in small but important ways. For example, a boy once ticked "always" to the RCADS item "I think about death." When asked further, he explained he was thinking

of Qiyama, the Day of Judgement: “It helps me put things into perspective and make good decisions.” What might have been pathologised was, in cultural context, a protective factor.

For many, intersectionality was not an academic concept but the daily reality shaping children’s distress. Participants spoke about supporting families affected by extreme domestic violence, poverty, housing insecurity, and racism. Participant 1 noted: “Where a smaller percentage of a population might be Muslim, they’re massively overrepresented in the most deprived groups...so many of the families we work with, the child’s difficulty is impacted by huge housing problems, trauma, racism, quite apart from other things.”

Community contexts also meant facing the reality of serious youth violence and gang involvement, which shaped how young people could come into the work. Participants spoke about boys already caught up in violent peer groups, and how knowing the risks and the codes they were living by could open a way to trust. For some, outreach meant finding a way in through activities with enough pull, like football, that could create a first step towards therapeutic contact.

4.2 The Psychoanalytic Offer, Redefined

4.2.1 The therapeutic offer

Participants reflected on how the psychoanalytic offer was not lost in outreach, but redefined. Participant 2 resisted the idea that this was merely “applied work,” insisting instead:

People often say oh, you’re doing applied work...I’ve always fought against that. I’m not doing applied work. I am doing psychoanalytic psychotherapy in the rawest, truest sense, because I’m on my feet and I am talking about death, literally, for some of the young people...you’ve got to keep your mind focused...not being distracted by anything.

Adaptations often combined individual therapy with staff consultation, parent work, and informal support. In nursery settings, the offer also included supporting staff. One therapist described being asked to speak on inset days, for example after two parents had died, when staff were unsure how to respond to the children. This kind of consultation reflected the wider reach of the role and showed how the therapeutic offer extended beyond direct work with children.

Therapists also valued brief supportive chats alongside formal therapy, recognising that both could be meaningful depending on the young person's readiness. In one service for Muslim heritage families, trust was built through faith-sensitive practice: "It's not counselling, it's child psychotherapy...it's not about religiosity. It's about identity and how families see themselves. My instinct was that this was important in terms of trust...again and again that's been confirmed. People say, 'you get me.'"

What also stood out was the creativity with which participants found ways into young people's experience. Some used unconventional methods to make unconscious states tangible. In one school, cubicles usually associated with punishment were reframed as a form of containment. Words like "depression" and "anxiety" were placed on the walls, inviting children to reflect on the feelings they stirred. In this way, what looked like a behavioural strategy became a psychoanalytic intervention, helping young people face and symbolise what felt overwhelming.

These innovations were not confined to schools or community projects. One participant described bringing the football method into prisons, working with young men convicted of violent offences. By restructuring the game to slow down impulsive play, the project aimed to help them hold violent feelings rather than act them out: "If you can open the pitch, you can open the mind. Once the mind is open, decision-making becomes possible." Even in a place like prison, psychoanalytic thinking gave a frame to

work within. It showed how the offer could stretch to young people often thought of as out of reach.

The football project itself illustrates this creativity. Therapists used the pitch to externalise states of mind, linking a young person's ability to control the ball with their capacity to manage proximity, boundaries, and feelings: "The ball is an externalisation of the mind. If you can control the ball in a thoughtful way, it tells us where your mind is... We created drills to raise anxiety, to work with those feelings, and then linked it back: if you can hold yourself on the pitch, you can hold yourself in the classroom... You don't realise what you're doing. And that's the crux of it in a way, it's all about the football... that's why it's edible. That's why it's digestible." Here, psychoanalytic ideas such as transference, projection, and containment were reframed through sport, showing how ordinary activities could be used to make unconscious states thinkable.

Running through all these adaptations was psychoanalytic thinking itself. Participant 1 described it as the anchor of the offer: "I think it's a really helpful framework to have in mind something you've internalised and keep with you. It gives freedom to explore what is unspoken and unconscious, and to think about transference even when the setting looks very different." Participant 4 described the usefulness of theory itself in outreach contexts: "The concept of the core complex is extremely helpful to me, because I see it in action a huge amount...the whole theory about separation, individuation in toddlerhood and in childhood...I do have an Anna Freudian framework, a developmental approach, and I find that very helpful for children under the age of five'.

4.2.2 Boundaries and Holding the Frame

In outreach, the frame is tested on many fronts. It is both a physical structure and a state of mind, and therapists described having to hold onto both if the work was to feel safe.

Participant 1 described how working outside the clinic could place extra pressure on the frame:

you kind of turn up to your little, tiny room and it's full of chairs stacked up to the ceiling, so you have to go. We try as far as we can to maintain the therapeutic setting, the time, the box, the things that we can but sometimes it's not in our control...we wouldn't take it on if we thought we were going to have to move rooms every week. It's got to be reasonably predictable.

Participants illustrated how they struck the delicate balance between working flexibly and holding the frame. Even where adaptations were needed, there were still limits and conditions. The work may not be as rigid as the clinic, but it was also not without form or outside a helpful container.

Whilst all participants valued the conventional frame a room, the same time each week, the materials where this was not possible the emphasis was that the frame had to be carried inside: "I couldn't always do it at the same time, same place...but what I began to feel is that I was the box and I was the room."

The internalisation of the frame gave therapists a way to stay flexible when external resources were lacking. It helped them hold consistency in uncertain conditions and continue the work even when the setting was far from ideal.

This became even clearer in exposed settings: "You are the container...because you're in an open space, it's completely different to be the container. If they see a chink of light, they will go through it and the whole thing falls apart." Participant 3 described stepping in when fights broke out, explaining that the work could only continue if the therapist held the boundary in that moment.

Maintaining the frame was about holding onto what was essential and adapting what could change. It meant being clear about role boundaries, setting limits when safety was at risk, and knowing when to step back:

There was a real pull to do more...he'd want me to read documents for court. And I think you have to be quite boundaried, but at the same time saying yes, we are here for the child, but that is not my role. I can signpost and get other people involved in the network that can do that side of things better. (P1).

The positioning of the therapist, often drawn into the community for various reasons, can make this boundary harder to hold as does working so closely with communities where disparities, vulnerabilities, and lack of resources are difficult to ignore, perhaps alongside the fear that if you don't help, who will.

Participant 3 gave an example of resisting pressure to cover wider family work:

We get invited to external child-around-the-family meetings, and we turn them down because that's not our role. We have a particular role to play, and that's the role of schoolwork with the child. School asked me to call the parent. I said, no, you call the parent. What I'm doing, I'm working with the child. You work with the parent, so we hold good boundaries.

Outreach work therefore required therapists to keep boundaries in mind and stay alert to how easily they could be pulled or tested. The frame, whether through a predictable room, the therapist's way of holding the work, or the ability to resist being drawn beyond role, was described as what allowed the work to happen.

4.2.3 Therapist role and identity

The role and identity of the therapist was an integral part of the interventions in outreach work. Therapists adapted their language, appearance, and interactions to build trust

while keeping boundaries in mind. identity was always part of the work and used thoughtfully to open a connection.

Clothing and presentation mattered. Being recognisable and approachable could change what young people could take in. Participant 3 explained: “I could go in there in a shirt and tie, be the same guy, give the same message, but it’ll be heard completely differently...in a pair of Air Max and a black tracksuit I’m the same person, but they hear me completely.” Practitioners described choosing clothes that set them apart from teachers and marked them clearly as part of the project. This signalled belonging and gave them “another minute or two” with a young person in difficulty, while still keeping the boundary in place.

Titles were also used carefully. Participant 1 “Even the fact that I’ve used ‘Dr’ – there’s a transference to the title. I’m very aware in different cultures...sometimes it helps, sometimes it creates an idealised idea of what I can do. But it can contribute to trust.” The use of “Dr” was seen to affect how trust and authority were perceived. Across accounts, the therapist title was often implied rather than stated with formal titles only used when helpful.

What counted as ordinary disclosure such as faith or race was also explored. This was seen as different from inappropriate sharing of information, and as an active part of the therapist’s role in outreach. Shared identity could help young people feel seen from the outset, whether in terms of faith, race, or gender. In the football project, all the young people were boys, while in nursery setting, therapists who spoke parents’ languages said this helped families feel at ease and more willing to engage. These forms of disclosure were described as meaningful, and part of the therapeutic offer.

Despite these adaptations, participants emphasised the importance of keeping thinking alive. As one put it, the role was to “retain your thinking mind... you’re not there to just join in the fun, but to think about it.” Maintaining reflective functioning and

staying grounded in the therapeutic role was described as what allowed psychoanalysis to be carried into community spaces without being lost.

Therapists described their identity as something that could help build trust, but also something they had to think about and manage carefully.

4.3 The Emotional Texture of the Work

4.3.1 Relational work and containment

Participants described relational work and containment as central to outreach, much as they are in clinics, though shaped differently in community settings. Trust, consistency, endings, and ordinary forms of contact were all part of what made the work containing, giving young people a chance to test reliability, bear frustration, and experience being held in new ways. This was also described as the psychoanalytic offer itself, showing how relational work and containment carried psychoanalytic thinking into outreach contexts.

Trust was described as something that had to be earned over time. Young people often came with the expectation that adults would let them down or disappear, echoing deep anxieties about being dropped or abandoned. One participant explained:

Initially, when a child comes into the unit, they'll kick off, because their expectation is, well, if I kick off, they'll tell me to go away...we're like you don't need to do that ...worst case, we call it an end for the day, and I'll see you at nine o'clock tomorrow morning. This freaks the daylights out of them.

What began as an assumption of exclusion could become a new experience of containment and repair.

Containment was described in very practical terms. One recalled a boy whose mother froze when he became violent, leaving him terrified by her fear: "A child like that, if that child can be met by an adult like me, who is calm, that helps the child calm,

because he feels contained.” This illustrated the wider task of holding disturbance and chaos without becoming punitive, creating space where strong feelings could be absorbed and thought about rather than acted out.

Relational depth came through in ordinary encounters. “I would never do the kind of silent waiting for them to speak. I'd always say, ‘Yeah, this must be really weird...sitting in the room with a woman like me’ and then we’d have a laugh.” (P2). Openness and proactive engagement were described as ways of breaking down suspicion and beginning to think together. At times this took the form of shared reflection, “two minds” working something out side by side.

Endings and transitions were recognised as particularly charged, often stirring fears of absence and loss. Therapists described preparing young people for breaks, helping them anticipate and tolerate the feelings these brought up. In this sense, endings became part of the containing work itself, testing and sustaining trust over time.

4.3.2 The emotional demands and impact of the work

Participants spoke about both the emotional demands of outreach and the impact it had on them. They tended to describe the demands of the work more openly, while the impact was often implied or mentioned in passing rather than explored in depth. What came through was not only the stress and emotional strain, but also the rewards. Their accounts touched on how outreach had affected them personally as well as professionally. Outreach was described as work that asked therapists to contain others but also left its mark on them.

The demands came through clearly. One therapist recalled supporting at least six families where one parent had been murdered by the other, sometimes in front of the child: “so it’s that, that level of extreme trauma.” Participant 2 described how much of the work required staying with young people’s proximity to death, both literal and

emotional: “I am talking about death, literally, for some of the young people, and you’ve got to keep your mind focused.” Participant 3 spoke about the sadness of this work, not only because of what children were facing, but because of how often they had been failed by the adults around them: “it’s very, very sad, but it’s the reality of what we’re working with.”. These examples highlight how therapists were repeatedly confronted with trauma and disturbance, and how much it asked of them to stay emotionally present.

Alongside these demands, participants described the impact the work had on them not only in their professional role, but also in their own lives. Some reflected on the warmth and vitality they experienced in their contact with young people and described how the work restored a sense of belonging and purpose: “I love these kids...they make your heart warm, yeah, never mind what they’ve been through...it really has kept me connected to life and not to give up...it’s given me a place where I feel I belong, and I can do something helpful but also get something back.” (P2). For some, the changes they witnessed in young people were profoundly moving. These reflections show that the impact was not only heavy but also deeply sustaining.

Participants also spoke about what supported them to manage the emotional intensity. Peer supervision groups, reflective team spaces, and personal analysis were all described as essential. One therapist noted she could not do the work in the nursery without the depth of her own analysis and regular supervision, given the intensity of countertransference that arose. Two participants described intentionally building a sense of team belonging to sustain resilience.

The emotional demands of outreach were therefore constant, sometimes overwhelming, but they also left their mark in more hopeful ways. The work could be painful, life-giving, and transformative, often all at once.

4.3.3 Parents and networks

In some outreach projects, parent and network work was introduced as part of the offer, relevant to the context of the setting and intervention. As the data unfolded it became clear that this often a vital foundation at times a lifeline without which the work with children could begin. Parent work frequently preceded any direct therapeutic contact with the child, acting as an anchor that enabled trust to be established with families. In projects working with adolescents, therapists spoke more about networking, while in early years and child-focused settings, parent work was central.

For some families, trust could only be built when therapists showed a willingness to understand and respect faith and cultural identity. Participant 1 explained:

a main concern amongst parents is, how do I protect my child growing up as a Muslim in this society...if their child is questioning their faith identity, they worry that the therapist might encourage them and say, 'don't worry about that, just be your true self,' which minimises the significance of faith identity.

Parents described feeling reassured when their values were held in mind, which in turn opened the way for child-focused work. In some community-based services, parental trust was a condition of access. As one participant recalled: "We were introduced to this group and they were like, you can't see our children until you've worked with our parents, because the parents won't support the child to go to therapy unless you've really established a trust and a relationship." This showed how parent engagement was valued not only within psychoanalytic practice but also by the communities themselves.

Where therapists worked mainly with adolescents, there was more emphasis on networks. One participant described:

Within schools we link with everybody...the pastoral set-up and social workers who link into us as well. Because of the children we are working with, we're asked to report...interestingly, we often know more generally than anybody else...information-wise, because of the children.

This showed how therapists were not only part of networks but often became central within them, holding responsibility for information and acting as conduits across systems.

4.3.4 The Power of the Ordinary

A powerful pattern across the data was the role of ordinary, everyday ways of being and speaking in making therapy accessible and meaningful. Participants described how reducing jargon, softening clinical language, and meeting families in familiar terms helped dismantle stigma and create trust. The “ordinary” became powerful because it bridged the gap between psychoanalysis and community life, moving it from something distant to something children and families could connect with.

Participant 4 explained:

What is key to the success of the service is to come across as very ordinary and use very ordinary language, because I really don't want to alienate the staff... when I arrived, people thought I could read their minds, the classic. So I have gone out of my way to be ordinary, use ordinary words... saying things like, all behaviour has a meaning. We as adults might not understand it, and that is our task

Using plain language to translate psychoanalytic ideas not only supported staff but also made the work feel relevant in day-to-day life. Ordinariness also came through in therapists' presence and approach:

I probably did make a fool of myself... but I think there's something about me being just ordinary. I would chat...comment on a girl's hair or dress. I'm not going to overstep, but equally I'm not going to be prissy and stand on ceremony.

Small moments of conversation or playfulness were described as helping to melt the emotional ice, softening suspicion and making it easier for young people to warm up to the work. For others, ordinariness meant being visible and available sitting in rehearsal rooms, joining in games, or taking part in activities like sport or creative work. These

everyday encounters reduced the fear of therapy and offered another route in, with young people sometimes reaching out later for therapeutic support.

4.4 Making it Work in Practice

4.4.1 Flexibility and adaptation

Participants showed a resilience in their ability to carry out meaningful work under shifting and often difficult conditions. Their examples revealed a spirit of flexibility and even entrepreneurship – a willingness to adapt quickly, to improvise with what was available, and to respond to circumstances without losing their therapeutic stance or identity.

Participant 3 recalled how flexibility was there from the first session. What started as a straightforward session immediately turned volatile.

The initial idea was that we were going to run a straightforward football session and have a discussion group after, but within about 30 seconds, someone punched someone straight in the face. And I started just verbalizing about why he did it. And we just started to ‘ad hoc it’, ...we carried on and I was just verbalising

Rather than shutting things down, the therapist responded flexibly to the enactment, putting words to action and turning chaos into a chance for meaning.

Flexibility was also described in more personal encounters. Participant 2 spoke about a young woman who sometimes arrived in great distress, and on one occasion brought her dog:

She would come in, sometimes in a real state... sometimes she’d bring her dog in, which wasn’t allowed in the theatre, so we had to go outside. Well, let’s just go with it. Not that I like dogs very much, but I did sit in the park with her and just try and keep focusing on what she’s telling me.

Here, the ordinary act of going outside became a way of keeping the work alive when the frame was stretched. Participants described similar adjustments: moving a session online when a room was suddenly lost, offering short phone calls to teenagers refusing school, or meeting children in school rather than in the mosque. Participant 2 spoke of the constant need to “scrabble about” when young people texted at the last minute to rearrange, adapting times or offering a call later in the week if that felt necessary. These adaptations were not about diluting therapy but about sustaining contact by using clinical judgment.

Perhaps the clearest example of systemic flexibility came from a nursery-based project, where therapy could begin immediately after a traumatic event:

I worked with a family where the little girl was in the bedroom when her smaller sibling choked and died...the girl received therapy immediately in the nursery by a trainee that I could set up. The older brother, who was at primary school, sat on a waiting list for a year...the big advantage of me being in the nursery was that I could see the family the next day.

The freedom to adapt made a significant difference for families seen in outreach. It allowed therapy to be responsive at the point of need, and in some cases to prevent difficulties worsening while children waited to be seen elsewhere. Participants took pride in their ability to work in this way while still grounded in psychoanalytic practice, showing that flexibility and adaptability did not mean abandoning the frame but stretching it to make the work possible.

Flexibility also showed itself in how therapists worked with parents and networks. Non-attendance was not met with closure but with persistence and new attempts to reconnect. Sessions could be shorter or less frequent if that was what families could manage, showing a willingness to adjust while keeping the work therapeutic. Therapists described being creative in finding ways to meet young people

where they were, their stance to the setting while holding on to their professional identity.

4.4.2 Working in Partnership and Collaboration

Outreach work was described as impossible to do in isolation. Partnerships were needed at every stage, from project inception to daily work. These collaborations extended across CAMHS, schools, nurseries, voluntary and faith-based organisations, but also included communities themselves. What came through strongly in the data was that partnership was not an occasional extra but a constant stance: therapists worked *with* rather than *for* communities, making the work feel embedded rather than imposed.

In many cases, projects were born out of partnership. Participant 1 recalled how a service grew after contact with a mosque's adult counselling lead, who recognised the need for child provision and reached out to collaborate: "people who'd see her would say, I'm worried about my child...she got in touch with me and said, would you like to set something up?" This model grew organically from the community, allowing families to engage more naturally.

Elsewhere, projects grew out of institutional partnerships. The nursery-based service began through collaboration between a headteacher and CAMHS, after the head recognised the value of having a child psychotherapist in the school. In other cases, faith communities-initiated services after recognising gaps for children, with therapists invited to build on existing trust.

Partnership also meant linking families with wider sources of support. Being based in community settings created opportunities to join the dots: "Sometimes in the community centre, there are other avenues to get support, and so we can link them...we do quite a lot of that." The work was less about duplication than about connection, ensuring families were not left to navigate systems alone.

Therapists spoke about collaboration as creative and evolving. Some partnerships thrived, while others were tried and did not last, but even these experiments were seen as part of the process: “we started a collaboration with youth theatre...it didn’t work out for various reasons. But these are all things that I think are a great opportunity to try...we’re always learning as we go along.” (P1). The willingness to test new collaborations reflected recognition that no single service could carry the whole task.

Participant 1 also highlighted the variety of relationships they were required to hold: “Because we only work through community organisations, you’ve got that relationship with the school to be navigated, or with the mosque, or with the different charities we work with. They’re all different...how they approach things.” This illustrated how partnership was not just about forming links but about adapting to the culture and style of each organisation to sustain the work.

At times there was a wish for more coordination and stronger community links. Participants emphasised that outreach psychotherapy could only work when embedded in shared effort whether through formal agreements, ad hoc problem-solving, or slowly built networks.

4.4.3 Holding Risk and Safeguarding

Safeguarding in outreach is not less rigorous than in CAMHS, but it is managed differently. Therapists described holding risk without the scaffolding of a large service. Safeguarding in outreach was managed relationally: in supervision, in the team, and with networks families could trust.

Risk was not seen as static but as something that often revealed itself more fully over time. Initial impressions could be misleading, with the real complexity only becoming clear once trust was established. One therapist (P1) explained how what

began as a seemingly straightforward case soon escalated, leading to intense supervision, regular policy review, and eventually referral on:

We do as much network liaison work as possible to hold the risk...sometimes you might start off thinking it's quite straightforward, and then all of a sudden, it's not...it was really through hands-on supervision that we managed it, and in the end we involved the family and referred the young person to CAMHS.

This showed how safeguarding in outreach relied on responsive supervision and ongoing policy review.

For some projects, the risks were immediate and external. Therapists described searching young people daily for weapons or creating clear rules on the football pitch to stop disputes spilling onto the street. The danger was not only to individuals but to the whole group, including practitioners themselves. Participant 3 captured this vividly:

Most of what the children we're working with are unconsciously suicidal...unless you're suicidal, why would you place yourself in a position to get killed? The risk to us as practitioners is we're always at risk of getting stabbed. I do have to go on the street.

This account showed how the risk was twofold; suicidal states of mind placing young people in danger, and the very real threat this created for staff working with them.

Safeguarding also relied on clear agreements about how responsibility would be shared. In one project, participant 2 had an explicit arrangement with community founders: "If somebody tells me they are suicidal, then I want to be able to phone you and for you to come and support me getting them to hospital." These partnerships were a necessity, distributing responsibility and ensuring therapists were not left to hold risk alone. In other examples, therapists joined child protection and child in need meetings, liaised with GPs or housing, or built safety plans during holiday breaks.

Safeguarding looked different again in early years work where risks were could easily be missed: signs of neglect, sexualised behaviour, or children posing risks to others. In the nursery intervention, safeguarding was led by experienced staff, with the therapist supporting where appropriate:

Safeguarding issues are handled within the nursery...the safeguarding leads go to the meetings. I occasionally write a report, but on the whole, I don't go, which protects my relationship with the family. More than half of my cases are known to children's services.

This shows how safeguarding is be embedded in existing systems while still allowing therapeutic work to continue.

Participants described the effort needed to maintain contact with young people at risk, aware they might withhold information about weapons, gangs, or threats of retribution. Safeguarding in outreach therefore meant facing risks that extended beyond the individual, sometimes touching families and communities.

What emerged was an image of safeguarding as an active and flexible process. It was never managed passively or in isolation, but through constant vigilance, relational connection, and shared responsibility. Without the safety net of a large institution, containment was established through clarity, collaboration, and the willingness to face risk directly.

4.4.4 Challenges and Limitations of Outreach

Participants described the challenges and limitations of outreach as part of the work itself, not something on the edges. The accounts showed how fragile these services can be, how easily gains can be undone, and how much depends on systems around them. One difficulty lay in the handover back to schools and services. Therapists spoke about how progress made in outreach could be lost if the environment a child returned to could not hold them:

They finish with us on a Friday, and they just drop them straight back into maths on Monday at nine o'clock. The teacher hates them...the child feels completely persecuted, does something, then they kick them out. Then it's done

This showed how transitions were as delicate as the therapy itself, with systems positioning young people to fail even after progress.

Cuts to early years services were also felt as a loss. Outreach used to sit within broader children's centres that included midwives, playgroups, and family support teams. Over time, these integrated services were stripped away. Participants reflected that something valuable had been lost, with outreach now taking place against a backdrop of a politically stripped landscape rather than embedded in wraparound provision.

The practical side of the work often created its own challenges. Therapists often worked in borrowed rooms that were unsuitable or unstable. One recalled being placed in a "fishbowl" at the top of the stairs, with a glass door:

I went across the road, bought some brown paper, stuck it on... I brought this young man in, and he said, 'hmm, it reminds me of the holding cell at the police station.' I said, well, I'm sorry, but the door is open. You may go whenever you like.

The attempt to make the room usable was also a reminder of how environments could evoke trauma, and how therapists had to adapt to preserve safety and dignity in inadequate spaces.

Funding remained a constant pressure. As participant 1 put it: "This is something that's really worthwhile, but the funding is a massive problem. I don't have a background in fundraising, and that is a problem." Another participant noted that reliance on voluntary models excluded those who could not afford to work for free. Participant 1 reflected that even a small payment for placements "like an NHS band

five” would open access and make training more sustainable, but this was difficult for organisations already struggling to secure funding.

Perceptions about Muslim-led services added another layer to funding challenges. Some participants described funders assuming these projects were “proselytising rather than clinical” (P1), which shut doors before the work was even understood. Participant 1 also spoke about being idealised or expected to “do everything” because they came from the community. Both dynamics distorted how the work was held and valued.

4.5. CAMHS vs Outreach: Two Different Worlds?

4.5.1 Contrasting Models and Expectations

One of the clearest differences lay in the very existence of formal referral systems. CAMHS requires families and clinicians to frame a child’s difficulties within diagnostic thresholds. As participant 4 therapist explained: “I end up giving the reason for referral for all my little patients as anxiety, which is not really adequate, but the CAMHS criteria are just not well suited for children under the age of five.”

This illustrated how difficult it could be to fit the complexity of family life into categories services would recognise. Outreach models, by contrast, aimed to minimise thresholds, making support available without the bureaucratic barriers.

Some aspects of the therapeutic frame were similar to CAMHS practice. Participants working with younger children, followed a standard approach to assessment: “I always start by meeting the parent...will do the developmental history... the toys are the same, each child has a box.” (P4). Participant 2 described less formal entry points but still highlighted the importance of boundaries and structure: “There’s an

induction, they can ask questions...they're told exactly what it means, and they sign a contract...no different to a therapeutic contract.”.

Some participants used a more formal CAMHS-style framework for assessments, while others worked informally, relying on clinical judgement and avoiding duplication “If they've had CAMHS involvement already...they might have done RCADS or SDQ, and we don't do it all over again. We do the same pattern: assessment, initial meeting, review but not in a rigid way, because sometimes the young person can barely think of a goal at the start.” (P1). Across approaches, there was a shared emphasis on flexibility, assessments were only used when helpful and adjusted to what young people and families could manage at the outset. The focus was less on procedure and more on accessibility and responsiveness.

Outreach also created a sense of immediacy rarely possible in clinics: “A young man sidled up to me, and said, you a psychiatrist then and I said, no, I'm a [psychotherapist]. He said, you've got five minutes. How would you get that in CAMHS?” (P2). Moments like this gave young people a sense of agency in seeking help, allowing therapy to begin in an ordinary way rather than after long waits or at points of crisis.

Yet these freedoms also came with vulnerabilities. Some participants described how, without the safety net of an MDT, they often felt exposed “it's not like I'm going to be taking this to the team and saying, this is so and so, has anybody got a space? It'll be me.” (P2).

Others, such as participant 1 and 4 sustained the work by maintaining creative links back into CAMHS, such as monthly check-ins with liaison colleagues to share risks and stay connected. These links offered containment when day-to-day team support was limited.

4.5.2 Bridging and Working Across Settings

Participants described outreach as a practice of linking across settings, often acting as a bridge between families, CAMHS, and wider community contexts. This bridging was two-way: some young people arrived in outreach having previously been seen in CAMHS, even briefly, and this seemed to lay a foundation for further work: “There were some young people who had had some CAMHS experience...a limited number of sessions...they’d had an experience of talking, and now they found someone who could offer more.” (P2).

Equally, therapists spoke about outreach preparing families to use CAMHS later, whether by referral, co-working, or building confidence in therapeutic relationships: “There are young people that have come to us and then we’ve referred to CAMHS. Wouldn’t have gone to CAMHS initially.” (P1).

These bridges worked in both directions, outreach drawing on CAMHS structures where appropriate, and CAMHS benefiting from the trust and groundwork built in community settings: “There’s always a bridge there. It’s not that we hold all the golden nuggets and then hand them out to the community. It’s more about tapping into what’s already there and helping people make use of it.” (P2).

Participants described outreach as moving across community, faith, education, health, and social care contexts with a flexibility rarely achievable in CAMHS. For some, this bridging extended across multiple systems at once: “I tried to do something in that space in between, so I’m working with NHS services, social care, Third Sector organisations, and I’m trying to work with the mosques and the Islamic psychology trainings.” (P3).

Collaboration with CAMHS was also part of this picture. Therapists described ways of co-working with CAMHS: “We do quite a lot of co-working. For example, if CAMHS refer, they might keep the psychiatric side or hold that sort of risk, and then

we'll try and engage the family and the young person. We are part of networks for child in need, child protection.” (P1).

Overall, these accounts suggest that outreach was not about replacing CAMHS but extending it. By getting alongside young people in places CAMHS might not reach, therapists were able to build trust and readiness while still drawing on CAMHS structures for safety and support.

4.6 Indicators of Progress

This theme is purposely named indicators of progress rather than success. Participants described progress as subtle, symbolic shifts rather than neat or complete success. Progress in outreach was rarely linear. It was often messy, uneven, and fragile, but no less important.

Progress with young people was often gradual. Participants spoke about emotional regulation, the capacity to think, and symbolic shifts in how children could play or interact. In one project, change could be seen in the way children began to approach the game:

What would happen is the children will want to expel the uncomfortable feeling as quickly as possible by taking the shot or just smashing the ball forward or playing completely individually... and then after a while, they're playing in a completely different way, because they're thinking in a different way.

Participant 3 reflected on how changes in the game could be transferred into other parts of life, showing a growing capacity to reflect, delay gratification, and make links between feelings and actions.

Progress could also be felt in the emotional quality of the work itself. Participant 2 recalled being called in when a young woman was distraught after receiving a letter from a psychiatrist:

She was sobbing and crying...we talked it through and settled her down. Later she came up to me at rehearsals, gave me a hug...that to me is a sign of success, that there's a place where painful things can be thought about, and that might make them feel less frightening.

This example shows how progress can be measured in relational terms, being integrated into the life of a group, where psychoanalytic thinking could be experienced as ordinary and human rather than distant or elitist. Services and projects showed progress through growth, visibility, and recognition from families and professionals. One therapist described how a mosque-based service had gradually become established:

We didn't know if we established a psychotherapy service in a mosque whether people would come or not...I've noticed interest growing gradually. Referrals in the last quarter have been more than in the whole of the previous year. It's really shot up.

The rise in referrals and self-referrals was seen as evidence that the work was valued and needed, and that trust was building over time. At the same time, progress was not simply about expansion. Sustainability and quality were also treated as indicators of success. Participant 3 reflected: "I scaled the project up due to demand then scaled it back as I wanted to focus on the quality". These initiatives were driven by individuals mindful of sustainability and depth, linking progress to care for the work's long-term viability rather than short-term growth.

Participants described success as layered: small developmental shifts in young people, in parents beginning to think differently about their children, in services becoming more trusted and recognised. Progress was also seen in how projects were able to collaborate with families and other services, creating spaces where different parts of the system could begin to think together. In this sense, the very act of being commissioned, trusted, and sustained was itself understood as a sign of progress.

5. Discussion

The discussion that follows interprets the main findings in relation to psychoanalytic ideas and existing literature. It is organised around four areas: (1) reaching and engaging families; (2) the psychoanalytic offer, including how the frame and the therapist's role are shaped in context; (3) psychoanalysis in action, including activity, ordinary contact and new ways of making thinking possible; and (4) sustaining the work, including flexibility, safeguarding, progress and the limits of provision. Together, these sections consider how psychoanalytic outreach may widen access while also raising questions about the frame, the therapist's position, risk, organisational holding and what is recognised as meaningful therapeutic work. The chapter is followed by an evaluation of the study's strengths and limitations, and by implications for practice, training, service development and future research.

5.1 Reaching and Engaging Families: Motivation, Barriers, and Meaning

Across the four accounts, a central motivation was to bring psychoanalytic work to children and families who might not find their way to a clinic. This was described as practical, emotional and ethical: a responsibility to make contact possible. Altman (2009) cautions that psychoanalysis risks irrelevance if it remains behind consulting-room doors; the projects described here suggest one response is to take psychoanalytic thinking into places where children and families already gather. Earlier services such as the Brent and Brandon Centres similarly used walk-in and open-access models to lower thresholds, allowing help to begin before formal treatment was established (Novick, 1977; Baruch, 1995).

“Who is missing?” needs careful thought. Barriers to clinic-based help were not only practical but structural, cultural and symbolic, shaping whether support could be imagined as safe or usable at all. Experiences of racism, deprivation and exclusion may

influence whether institutions are approached as sources of care or threat (Bains, 2001; Lowe, 2010). Fears about authority or surveillance, captured in one participant's observation that families were "terrified of children's services," were understood as meaningful rather than simply as resistance. From a psychoanalytic perspective, expectations of judgement or persecution may become located in the institution, which can then be experienced as watching, judging or shaming. Access is therefore not only a question of removing practical obstacles, but also of whether help feels emotionally safe and possible to receive.

For two participants, developing outreach was directly connected to noticing who was absent from existing services. The movement of the service towards families may itself carry symbolic meaning: the first step has already been taken, reducing both the practical barrier of location and some of the institutional distance associated with seeking help. Outreach cannot reach everyone who remains outside traditional services. However, asking why people are missing, rather than treating them as resistant or "hard to reach," places some responsibility on services to consider how their structures and meanings may contribute to absence.

Meeting families in nurseries, youth projects and faith-linked spaces allowed contact to begin through ordinary conversation, play, activity and presence within familiar routines. One therapist recalled a young man who "sidled up to me and said, 'You've got five minutes?' How would you get that in CAMHS?" The moment captures more than immediacy. It suggests a shift in agency and power: the young person could initiate contact, control its timing and approach the therapist without first being identified as a referral or as someone with a problem. The therapist's visible presence in the wider setting may also have reduced some of the stigma and anxiety attached to therapy. Rather than appearing only when something was wrong, the therapist could be encountered as part of the life of the group, interested in ordinary activity as well as

difficulty. For some young people and families, anxiety about therapy may also have reflected intergenerational relationships to help and services: whether help had previously been experienced as available, intrusive, shaming or unreliable. In this context, psychological support could begin to feel less pathologising and more exploratory, creating space for young people to approach in their own time and bring what they wished. The relationship could therefore begin before it was formally named as therapy, while the therapist continued to hold professional boundaries and a psychoanalytic way of thinking.

Culture and community further shaped how help could be approached. Because outreach often took place in spaces already associated with particular communities, experiences of migration, racism, faith and difference were more immediately present within the therapeutic frame. These settings could function as symbolic containers for cultural identity and belonging. As Bargawi and O'Dwyer (2016) suggest, visibility alone is insufficient; belonging also depends on whether histories of migration, racism and mistrust are recognised and held in mind. Trust already invested in the community setting could extend towards the therapist, allowing psychological help to be approached through an environment and relationship that felt known.

This may also shape how feelings become distributed between community and statutory systems. Statutory services could come to carry feelings of authority, surveillance and distance, while community settings more readily carried feelings of acceptance and belonging. This may be understood as a form of systemic splitting. As Halton (1994) argues, splitting and projection are not confined to individuals but also operate within institutional processes, shaping how authority and care are experienced.

Community settings were not, however, free from transference tension. Anxieties about therapy, emotional exposure and being known could also emerge there, suggesting that safety and threat did not belong permanently to one setting or the other.

The therapist's position at the boundary involved holding both states of mind without confirming one service as wholly caring and the other as harmful. In some accounts, trust established through outreach later enabled engagement with CAMHS, while CAMHS continued to provide institutional containment and hold aspects of risk. The value of outreach may therefore lie not in replacing statutory provision, but in creating a link through which anxieties about help, authority and belonging can begin to be recognised and thought about.

Engagement itself emerged as part of the therapeutic task. Clinicians responded to missed sessions with thoughtful persistence, reopening contact and adapting when attendance became difficult. Such actions communicated that the young person remained in mind, echoing Baruch's view that engagement may be central to therapeutic work with adolescents (Baruch, 1995, 2001). Adolescents at risk of exclusion are often absent from clinic populations (Wells, 2001); within these accounts, absence was approached as communication rather than automatically as a reason to close. Persistence could therefore function as containment in action, conveying that ambivalence, separation and uncertainty could be tolerated without the relationship immediately being withdrawn.

Referrals often came through nursery staff, teachers, youth workers or others whom families already trusted. This suggests a tolerance for the not-yet-known: contact could begin before a formulation was fully established, with understanding developing through the relationship rather than being dependent on prior categorisation. This does not remove the need for assessment, boundaries or decisions about what can safely be offered. It does, however, suggest that engagement should be recognised as clinical labour rather than treated simply as an administrative stage before therapy begins.

Overall, the findings suggest that outreach responds not only to practical exclusion but also to the meanings attached to help and the institutions offering it. Its

contribution may lie in creating conditions in which contact becomes more possible, while linking families with wider systems of care rather than positioning itself as a replacement for them.

5.2 The Psychoanalytic Offer: The Frame and the Therapist's Role

One of the questions raised by this study concerns what the profession recognises as psychoanalytic work. The literature suggests that adaptation can create anxiety about whether something essential is being lost, particularly when practice moves away from the familiar arrangements of the consulting room (Music, 2004; Altman, 2009). A consistent setting, time and therapeutic boundary all serve important functions. However, there is a danger that these external arrangements become treated as the defining features of psychoanalytic practice, rather than as structures intended to support a particular kind of emotional and relational work.

This tension became especially visible in one participant's response to the suggestion that her outreach practice might be described as "applied work." She rejected this forcefully, describing it instead as "psychoanalytic psychotherapy in the rawest, truest sense." The intensity of her response seemed important. It suggested that the psychoanalytic status of work undertaken in community settings may not be assumed, and that practitioners can feel required to establish its legitimacy. Her words may also point towards an implicit hierarchy within the profession, in which clinic-based work is more readily understood as psychoanalytic, while work that uses different settings, activities or forms of contact risks being viewed as something less.

The question is therefore not simply whether the traditional frame can be altered, but what the frame is understood to protect. If its purpose is to support continuity, containment and attention to unconscious meaning, then it may be possible for its external form to change while these functions remain present. The accounts offered

examples of therapists using sport, play, ordinary conversation and direct responses to live situations, while continuing to think about what was being communicated through behaviour and relationship. These practices looked different from conventional clinic work, but difference in form did not necessarily indicate an absence of psychoanalytic thought. At the same time, the interviews did not always explore in detail what happened within sessions themselves. Participants did give examples of being with children, noticing how they used the room or how contact became possible, but my questions often stayed at the level of the offer, the setting and how the work developed. This may have meant that some of the finer clinical detail remained implicit. It may also reflect my position as a CAPT, where I perhaps assumed a shared understanding of what was meant when participants described the work as therapy.

This was captured most clearly in one participant's reflection: "I was the box and I was the room." The statement suggests that, where the external frame was less dependable, the therapist had to carry more of its containing function internally. Continuity rested not only on the physical setting, but on the therapist's capacity to remain emotionally present, maintain a thinking position and hold the meaning of what was unfolding. Altman (2009) proposes that changes to the outer frame can make analytic functioning more visible rather than necessarily diminishing it. In these accounts, where the room itself could not be relied upon to provide containment, the therapist's capacity to remain thoughtful and emotionally present seemed to take on greater importance.

This internal frame appeared to shape the therapist's role. In outreach, therapists were sometimes required to respond more directly and immediately than might be expected in a traditional consulting room. They could not always rely on silence, distance or a protected setting to create space for thought. At times, thinking had to take place in the midst of activity, disruption or strong emotion. This did not necessarily

mean that reflection had been replaced by action. Rather, the action could itself become part of the analytic response when it was informed by attention to meaning.

The distinction may therefore be less between an active therapist and a reflective one than between action that is thought about and action that is merely reactive. A therapist might interrupt a fight, join an activity, speak more directly or adapt the form of a session, while still asking what was being communicated and how their response might be experienced. What appeared important was the effort to retain curiosity and a thinking mind while also responding to the immediate demands of the situation.

This complicates more traditional ideas about therapeutic neutrality. In outreach, the therapist was often more visible as a person. Their tone, language, appearance and way of entering the setting could influence whether contact became possible. Shuttleworth's (1999) description of child psychotherapists as "border people" is useful here, as the therapist was often moving between professional, institutional and community worlds. These aspects of the therapist were not outside the work, but part of how authority, difference, familiarity and trust were experienced. The task was not to remove the therapist's identity from the encounter, but to think about how it was being used and understood.

This more visible role also raised questions about boundaries. Outreach required some flexibility, but not an absence of limits. The important question was what a particular boundary was protecting. Some changes in time, place or form could support contact without undermining the therapeutic task. Other requests risked pulling the therapist into roles that belonged elsewhere in the network. Emanuel (2016) suggests that pressures on the frame can become part of the clinical material, expressing anxieties about abandonment, intrusion or dependency. In this study, such pressures could carry emotional meaning, including dependency, urgency or a wish for the therapist to resolve wider difficulties. They could also reflect real gaps in provision. A psychoanalytic

understanding of these pressures should not obscure the practical reality that some services and families were under-supported.

There is also a risk in idealising the idea that the therapist can become “the box” or “the room.” It can suggest that sufficient clinical experience or internal steadiness can compensate for unstable settings, limited resources or weak organisational support. The accounts did not suggest that external structures ceased to matter. Privacy, predictability, continuity and role clarity remained important. Where these were absent, the therapist could be left containing not only the child’s emotional experience, but also anxiety belonging to the wider system.

The internal frame therefore had limits. It made adaptation possible, but could not replace the need for supervision, dependable relationships and clear organisational responsibility. McLoughlin’s (2010) idea of “concentric circles of containment” is helpful here. The therapist may hold the child or family in mind, but also needs to be held by colleagues, supervisors, host organisations and wider services. Without these surrounding structures, flexibility may become exposure rather than thoughtful adaptation.

This was also where the relationship between outreach and CAMHS became important. When therapy moved beyond the consulting room, the work depended on both proximity and structure: the possibility of moving closer to children’s lived worlds, and the presence of systems that could hold risk, responsibility and continuity. CAMHS offered structure, legitimacy and shared responsibility, while outreach offered proximity, flexibility and immediacy. Each model also carried its own risk: CAMHS could become rigid or retreat behind institutional procedures, while outreach could become exposed or over-extended.

Seen psychoanalytically, this relationship mirrors tensions within the therapeutic frame itself: between structure and freedom, protection and exposure, dependence and

independence. Outreach may represent the therapist's wish to move closer to lived experience, while CAMHS provides the institutional holding that makes such movement possible. The interplay between them can be read as a form of institutional transference: a working-through of anxieties about safety, control and how help can be offered without retreating from reality.

The relationship between them is therefore not best understood as a choice between two opposing models. The value of linking CAMHS and outreach may lie in allowing each to hold something that the other finds more difficult. In this sense, the tension between the two models echoes the central question of the frame: how to remain structured enough to contain, while open enough to meet the realities of the child's world.

The findings suggest that the psychoanalytic offer in outreach depended neither on reproducing the consulting room nor on abandoning structure. It rested on the therapist's ability to keep emotional meaning, unconscious communication and relationship in mind while adapting to context. However, this capacity was sustained by external as well as internal forms of containment. The therapist could carry more of the frame but could not safely carry it alone. The challenge, perhaps, is to keep finding ways to speak about the messiness of this work without losing sight of its value.

5.3 Psychoanalysis in Action: New ways of Making Thinking Possible

The accounts also challenged any assumption that outreach is a lighter or less emotionally demanding form of psychoanalytic work. Across the four projects, participants described work with children, young people and families experiencing multiple layers of difficulty, including trauma, exclusion, violence, bereavement, family disruption and experiences of being failed by adults or services. The nursery account, for example, included work with children and staff affected by extreme events, while

the youth-based accounts brought therapists into contact with young people living close to risk, exclusion and criminal exploitation. Outreach did not move psychoanalytic work away from emotional intensity. In some ways, it brought therapists closer to the circumstances in which distress was being expressed.

This closeness shaped the form the work could take. In a clinic, there may be more expectation that emotional experience can be brought into the room and gradually spoken about. In outreach, the work often began in less formal and more immediate ways: through ordinary conversation, play, movement, humour, shared activity, or simply being present in the setting over time. These forms of contact were not separate from the therapeutic work. They were often the way a relationship became possible with children and young people who may have had good reasons not to trust adults, services or direct emotional enquiry.

What feels important here is not simply that some young people may struggle to sit in a room and talk. The deeper point is that, for some young people, distress may already be held and expressed through the body: through movement, aggression, vigilance, avoidance, risk or action. This does not mean that talking therapy has nothing to offer them. Rather, it raises the question of how psychoanalytic work can reach young people whose emotional life may first appear in action rather than words. Where distress was communicated through action, the therapist's thinking also had to take place in relation to action. This kind of thinking in motion recalls Bion's (1962) concept of *reverie*: the capacity to absorb and transform raw emotion even while inside it.

This was most explicit in the sport-based project, and was also visible differently in the theatre, nursery and mosque-linked accounts, where the form of the setting shaped what could be approached. In the sport and theatre-related material, activity was not just a way of making therapy more attractive. It offered a medium through which energy, feeling and conflict could be given another form. Without this, violent or chaotic

feelings may remain located in action alone, potentially feeding cycles of exclusion, criminality or further failure by adults and systems. Within the outreach projects, however, activity and ordinary contact created the possibility that something acted out could begin to be held, slowed down and thought about. The game, the rehearsal, the movement, the shared task or the ordinary routine could become a place where the young person's emotional world was present, but not approached too directly.

This seems close to the way children sometimes use play in psychotherapy. A child may speak through a toy, a character or an imagined situation before they can say directly, "this is me" or "this is how I feel." In a similar way, the pitch, the theatre space or the shared activity could allow feelings to be approached at a safer distance. This resonates with Winnicott's (1971) idea of potential space: an area between inner experience and external reality where feeling can be played with before it has to be owned directly. The young person did not have to begin by naming vulnerability, fear or shame. These states could first appear in how they played, how they managed rules, how they used space, how they responded to limits, or how they related to others in the activity.

This suggests an important clinical implication: outreach may not only make psychoanalytic work more accessible, but may also alter the route through which emotional experience becomes available for thought. Sport, theatre, play and ordinary activity could create a less threatening route into emotional life, particularly for young people who had good reasons not to trust adults, institutions or direct therapeutic enquiry. The work was not psychoanalytic at every moment in an obvious way. However, the activity or ordinary contact could create the conditions in which psychoanalytic thinking became possible.

In schools, nurseries, or football projects, containment could not rely solely on words or silence; it was enacted through tone, humour, and a steady presence in the

midst of activity. Alvarez (1992) describes containment as an active, enlivening stance that makes psychic contact possible. In outreach this was visible when therapists met acting-out or withdrawal with calm persistence, creating a boundary that could hold both fear and aggression. What made this psychoanalytic was not the method but the state of mind: the capacity to keep thinking and stay emotionally present within the child's world. This required being both dynamically minded and analytically grounded: able to think on one's feet while remaining anchored as a containing figure.

The work exposed clinicians to intense and often raw experience: proximity to violence, loss and despair demanded both emotional availability and endurance. Participants spoke with understated gravity; grief and exhaustion sat beside deep affection and hope. This combination felt important. The therapist had to remain open enough to be affected, while also retaining enough thoughtfulness not to become overwhelmed or pulled into action without reflection. This suggests that outreach cannot depend only on the individual therapist's capacity to bear and think about the work; it also requires supervision, team thinking and organisational structures that can hold its emotional impact.

My own countertransference during the interviews, including sensing shifts in tone from pride to sorrow, underlined how charged these accounts were. I was often moved by participants' descriptions of children and young people who had been repeatedly failed, and by the commitment with which therapists continued to make themselves available. This emotional weight became a form of data: a guide to what had to be thought about rather than defended against. At the same time, my investment in the value of outreach may have made me particularly receptive to accounts of warmth, persistence and repair. I return to this more fully in the evaluation of the study.

The implication is that ordinariness in outreach should not be mistaken for informality or dilution. It was a stance that combined humanity with thoughtfulness, and

in this sense functioned as an antidote to the distance or mistrust that some children, families and communities may associate with services. It kept the work emotionally close, accessible and real, while still requiring analytic attention. The accounts therefore suggest that containment and psychoanalytic thinking can coexist within the ordinary relationships and rhythms of community life, provided the therapist is supported to remain reflective, bounded and held in mind by the wider network.

5.4 Sustaining the Work: Risk, Reality, and Progress

The findings suggested that outreach depends not only on making contact, but on sustaining psychoanalytic work within conditions that do not always unfold neatly. Sessions could change suddenly, settings could become disrupted, and practical realities could enter the work in immediate ways. These were not simply interruptions to the therapeutic task. They were part of the conditions in which the task had to be carried out. The significance of this is not simply that outreach required flexibility, but that the therapeutic task had to be kept alive within the realities of the work itself. This required therapists to keep thinking, relating and holding responsibility when the work was shaped by unpredictability, risk, limited resources and uncertain progress.

This was visible in the football project, where the therapist's description of having to "ad-hoc it" captured the need to respond in real time. This did not seem to mean working without structure. Rather, it suggested a readiness for the session to move suddenly into something more chaotic or dangerous, and a capacity to respond without losing the therapeutic task. When violence emerged, the practitioner had to stop what was happening, manage the immediate safety of the group, return to the activity where possible, and then offer words to help make sense of what had taken place. The act was both practical and psychological: externally containing the group while internally holding its meaning. In this context, flexibility was not looseness but reflective agility. It

involved knowing that the work might suddenly move off course, while still trusting that a therapeutic encounter could be made possible within disruption, resistance and instability.

What feels important here is the therapist's capacity to keep the link between action, feeling and thought alive. The words offered after the event did not only name big emotions; they showed that a thinking mind could continue to track what had happened, even when the group had become heated. Over time, this may allow young people to internalise something of that function: to begin noticing what feelings arise, when they arise, and what they do with them. The therapeutic task is therefore familiar, but the conditions are different. The therapist is still linking action, thought and words, but doing so in a setting where aggression, risk and group dynamics can quickly become part of the work itself.

Holding this kind of work demanded internal stability and reflective support. Participants spoke of drawing on supervision, experience, collaboration and their own analysis to stay grounded. Their confidence appeared to rest not in certainty, but in the capacity to think under pressure and hold the analytic frame in mind as it stretched to circumstance. As Emanuel (2016) suggests, when outer structures are unstable, the therapist may carry a "home in mind," offering consistency through thought rather than place. At an organisational level, this responsiveness seemed to be supported by the ethos of the projects themselves, which valued professional judgement and allowed therapists to shape the work to circumstance. What sustained outreach, then, was not adaptation alone, but the capacity to remain thoughtful, bounded and supported when the work became unpredictable. The implication is that outreach services need to build this unpredictability into the model itself: through supervision, shared decision-making, trusted professional judgement and structures that allow therapists to respond in the moment without losing the therapeutic task.

5.4.1 Risk

Safeguarding in outreach appeared as a central part of the work, woven through daily clinical practice rather than treated as a separate procedure. The distinctive difficulty was not simply that therapists were managing risk, but the form that risk took. In the accounts, risk was often contextual, covert and hard to evidence. It was not always located inside the young person as a clearly stated symptom or disclosure. It was also in the peer group, the street, the community, the school system and the relationships surrounding them. Safeguarding therefore involved reading behaviour, silence, avoidance, bravado, conflict, absence and atmosphere, as well as responding to what was spoken directly.

This was particularly clear in the football project. The therapist was not only thinking symbolically about risk; he was also managing it in very practical ways through searches, rules on the pitch, responding to fights and thinking about what might spill out into the street. His comment that “most of the children we’re working with are unconsciously suicidal” sat alongside the reality that practitioners themselves could be at risk: “we’re always at risk of getting stabbed. I do have to go on the street.” This combination felt important. The psychoanalytic work was not taking place at a safe distance from danger, but alongside concrete safeguarding decisions and real physical risk.

The idea of unconscious suicidality seemed especially powerful because it widened how risk might be understood. Suicidal states may not always appear as spoken thoughts of wanting to die. For some young people, destructiveness may be expressed through violence, danger, risk-taking, or becoming caught in situations where harm feels almost inevitable. Violence towards others could also carry violence towards the self. This does not replace ordinary safeguarding assessment, but it suggests that psychoanalytic thinking may help clinicians recognise forms of self-destructive communication that do not look like conventional clinical presentations of suicidality.

This also makes sense of why outreach may be needed. Young people living close to violence, exclusion or exploitation may not directly say that they are frightened, being drawn into danger, carrying weapons or at risk in the community. They may not experience adults or services as trustworthy enough for that kind of disclosure. The work therefore required therapists to stay close to forms of risk that were partly hidden and partly enacted. Outreach could make these risks more visible, not because it replaced statutory safeguarding, but because therapists were present in the settings and relationships where risk was already being communicated.

Participants described learning, often through experience, how to manage intense risk in settings that were less protected than clinics. The task was not only to assess danger but to stay in relationship with it: to keep thinking when the wish might be to retreat, control or act too quickly. This required a willingness to work differently, and to take considered risks in order to reach young people who lived close to danger every day. The “risk” taken by the therapist was therefore both symbolic and practical: a communication of endurance and care that showed frightening states of mind could be faced and thought about safely, while still requiring clear limits and real safeguarding action.

Risk was held collectively rather than left with individual clinicians. Supervision was frequent and accessible, and decisions were often shared with community partners or safeguarding leads. This collective thinking allowed fear and uncertainty to be distributed, so that no one person carried the full weight of responsibility. It also echoed what psychoanalysis at its best can offer: a capacity to hold anxiety in mind without acting it out. Where institutional structures were less established, therapists often recreated containment through peer supervision and collaboration, revealing both the vulnerability of the role and the creativity required to sustain it.

Working at the boundary between care and control brought ethical and transference tensions. Searching a young person's bag or setting firm limits could be necessary, yet risked being experienced as punitive, especially for young people already subject to surveillance, exclusion or racism. The work therefore required ongoing sensitivity to power, meaning and identity: to think not only about what was safe, but about how safety might be felt. Apart from knowing that such procedures were sometimes necessary, it remains unclear how these actions affected the transference or how they were worked through clinically. This is an important limitation in the accounts, and points towards the need for further research into how safeguarding interventions are experienced within outreach relationships.

The implication is that safeguarding in outreach cannot be held only through procedure. Procedure matters, but the accounts suggest that risk also has to be understood relationally and contextually. This kind of practice required therapists to hold risk both outwardly and inwardly: to respond to real danger while also thinking about what was being communicated through silence, action, bravado or violence. Psychoanalytic clinicians may be particularly equipped for this because the work requires tolerating uncertainty, staying in touch with conflicting states and continuing to think amidst threat. Outreach, in this light, may expand the idea of containment to include working at the edges of danger: staying close enough to understand without being pulled into panic or control. This requires therapists who can think psychoanalytically while also acting practically, and systems that can share responsibility when risk is live, contextual and difficult to evidence.

5.4.2 Realities on the ground

Participants also spoke openly about the pressures and strains of outreach, describing how easily progress could unravel. One therapist recalled a child completing an intervention on Friday and returning on Monday to a hostile maths class: “The teacher hates them...the child feels completely persecuted, does something, then they kick them out. Then it’s done.” The story captured how therapeutic gains could collapse when the environment around a child could not uphold them, leaving therapists to confront the pain of seeing progress dissolve for reasons beyond the work itself.

This felt important because it showed how close outreach can bring therapists to the conditions surrounding a child. Of course, all therapeutic work is shaped by the realities children return to outside the session. However, in outreach these realities may be more visible and immediate: the school, the peer group, the adults around the child and the institutional responses they meet are often closer to the therapeutic field. This can create possibilities, where the work can extend to teachers, parents or other adults around the child. It can also expose the limits of the intervention, where the wider environment cannot yet receive or support what has begun. The work therefore involves holding both hope and frustration: recognising moments of change, while also facing the reality that change may remain fragile when the child’s world continues to respond in familiar ways.

Participants also reflected on the loss of broader provision that once surrounded their work. Outreach had previously sat within children’s centres alongside midwives, playgroups and family support teams, but much of this provision had disappeared. The Future Minds Report (2025) echoes these concerns, warning that cuts and fragmentation have left families with fewer accessible supports, increasing the weight placed on small projects to fill the gap. The absence of wider holding structures affected the work at an institutional level. Therapists often carried anxieties that might once have been shared

across networks. The result was a sense of professional isolation, where containment had to be recreated each time rather than being held by a broader system.

Practical conditions added to this strain. One therapist described working in a “fishbowl” room where a boy compared it to a police cell, showing how the physical environment could evoke persecution before the session had properly begun. The challenge was not only logistical but emotional: the space itself could become part of the transference, evoking experiences of exposure or scrutiny that the therapist then had to hold and make sense of. Being embedded in community spaces made psychoanalytic work more reachable, but it could also carry painful resonances, reinforcing at times a sense of deprivation or difference for the children themselves. Therapists seemed to recognise this tension as part of the work’s texture: the offer of help was real, but so were its limits.

Funding pressures formed a constant backdrop, determining whether projects could continue at all. The uncertainty required clinicians to take on organisational roles, including advocacy, bid-writing and fundraising, far beyond their clinical remit. There was pride in what had been built, alongside awareness of its precarity. Yet reliance on voluntary labour raised questions about fairness and sustainability: who can afford to give this time, and what kind of service can survive on goodwill alone? These pressures are not simply background issues. They shape the therapeutic frame itself, because continuity, privacy, staffing and availability all depend on material conditions. The implication is that outreach cannot be sustained by clinical commitment alone; it requires investment, wider systems and conditions that allow the work to remain reliable.

5.4.3 Progress that is not linear

Amid these accounts, a question began to surface about how change is known – what it looks like, how it is recognised, and what it means to name it. Participants spoke

cautiously about change, hesitant to claim “success” and careful not to overstate what had been achieved. I found myself sharing some of that restraint. I came to think of these moments as indicators of progress: a way of acknowledging movement while holding on to its complexity. This modesty seemed emotionally grounded, perhaps a recognition that in this kind of work, progress can be easily tested and hope needs to be held carefully. The reluctance to claim success may also reflect an important clinical humility: an awareness that change is complex, partial and rarely owned by the therapist alone.

The changes described by participants were often subtle but deeply meaningful. One therapist noticed how children who once “smashed the ball forward” began, over time, to anticipate one another and play in a more thoughtful, cooperative way. What might seem like behavioural improvement could also be understood as a movement from impulsive action towards reflective engagement, and from isolation to shared purpose. The therapist’s presence within the group seemed to allow aggression to be transformed into connection. Another therapist recalled a young woman who, after a painful encounter, later sought her out and gave her a hug. The gesture was remembered not as proof of success but as a sign that distress could be thought about and survived within relationship. For young people whose experience of care has often been inconsistent, small moments of recognition like this may carry lasting meaning, suggesting that the work’s impact sometimes lies in the possibility of emotional endurance

Progress was also visible at a systemic level. When projects became established, trusted or sustained, therapists experienced this as more than organisational achievement; it symbolised the survival of reflective thinking within the system itself. Yet not all projects are meant to last indefinitely. Some respond to a particular need and reach a natural conclusion once that context changes. Perhaps this, too, can be seen as a

form of progress: when the work evolves, hands over, or ends while leaving something of its containing function behind, whether as a way of thinking, a model of relationship, or a memory of being held in mind that continues within the community.

A similar tension appears in the existing literature. Cioeta and Catty's (2021) audit is useful here because it showed both the promise and the difficulty of evidencing psychoanalytic outreach. The audit suggested that children and families were engaging with the service and that changes were noticed in areas such as friendships, emotional regulation, family communication and learning. However, the authors also recognised the limits of the data, which was incomplete and shaped by the realities of practice rather than research design. This does not show that outreach cannot be evidenced. Rather, it points to the difficulty of fully capturing forms of progress that may be gradual, relational and shaped by the settings in which the work takes place. This felt relevant to the present study, where progress could be observed in small but meaningful ways, while still being held cautiously.

The implication is that outreach may require broader ways of recognising, evaluating and speaking about change. Progress may lie not only in whether symptoms reduce, but in whether a child can pause, return, play differently, tolerate connection, seek help, or experience an adult as still thinking about them. At a project level, progress may also lie in whether a school, community or wider network becomes more able to hold children in mind. This does not mean abandoning formal measures of outcome, but it suggests that they need to sit alongside forms of evaluation that can recognise small, relational and systemic changes.

6. Conclusions

6.1 Strengths, Limitations and Future Research

6.1.1 Strengths of the Study

A strength of this study lies in the depth of the four participants' accounts and the range of outreach contexts represented. The projects differed in population, setting, intervention and organisational structure, including early years, school and sports-based work, theatre, and faith and community settings. This made it possible to consider how psychoanalytic thinking was adapted across different forms of outreach, rather than describing one model. Personally transcribing the interviews and returning repeatedly to the recordings also helped me stay close to participants' language, tone and emotional expression. This felt important because the interviews carried feeling as well as information: pride, exhaustion, hope, doubt and a strong sense of commitment to the work.

The study also benefited from my position within the same professional field as the participants. Being part of the CAPT community made it easier to build trust and to understand the professional language and clinical contexts being described. Participants could speak about the frame, containment, transference, safeguarding and CAMHS without needing to explain every term. This allowed the interviews to move quickly into the emotional and practical complexity of the work. At the same time, this shared professional background also required vigilance. It may have created assumed understandings, particularly when participants described something as “therapy” or “psychoanalytic work.” At times, I may not have asked them to unpack these terms fully because I felt I understood what they meant. This may have shaped the data by drawing out broader reflections on access, adaptation and service context more than detailed accounts of what happened moment by moment within sessions.

6.1.2 Sample and Participant Position

The study's limitations are mainly linked to scope, sample and method. As with all qualitative research, the findings represent perspectives rather than universal claims. The sample was small, with four participants, and each participant was interviewed once within a limited timeframe. The findings should therefore be read as patterns formed through engagement with these four accounts, rather than as a general account of CAPT outreach. The range of projects enriched the study, but it also meant that the analysis brought together interventions that differed considerably. In looking for shared meanings, there was a risk of smoothing over differences between, for example, work in a nursery, a faith-linked setting, a sports project and a theatre project. Some ideas were especially strong in one or two interviews and should be understood as possibilities raised by the data, rather than features of all outreach work.

A further limitation concerns who took part. All four participants were service leads, and some had also been central to establishing the projects they described. This was valuable because they could speak in detail about why the work began, how the therapeutic offer developed, how relationships with CAMHS or host organisations were built, and what affected sustainability. Their accounts therefore offered rich insight into the thinking of clinicians with responsibility for creating and holding outreach projects. However, this also means that the study privileges the perspectives of those most invested in the work. Participants were speaking about projects they had helped to develop and understandably cared about deeply. Their accounts may therefore have presented outreach in a more coherent or hopeful way, while conflict, uncertainty, failure or dissatisfaction may have been less available in the interviews. Some of the findings about creativity, persistence and personal commitment may also reflect the position of service leads rather than the experience of outreach clinicians more broadly.

The absence of other perspectives is important. This study cannot show how children, young people or parents experienced the flexibility, familiarity or accessibility described by participants. Nor can it show whether community partners, schools, nursery staff, youth workers or less senior clinicians understood the projects in the same way. The findings concern how service leads made sense of their work; they are not evidence of effectiveness or of service users' experiences. Future research should therefore include young people, parents, community partners and clinicians who are not in lead roles. This would help to build a more rounded picture of what makes first contact possible, what sustains trust and where the limits of outreach are felt. It would also allow researchers to explore whether adaptations intended by clinicians to feel approachable or containing are experienced in that way by children and families themselves.

6.1.3 Researcher Position and Reflexivity

The interview relationship also shaped the material. At the time of the interviews, I was a trainee interviewing senior and experienced clinicians. I respected their expertise and was genuinely interested in learning from work that felt important, creative and, in some ways, aspirational to me. Looking back, I think this affected how confident I felt in challenging participants, following contradictions or asking more difficult questions. I became more aware of this during analysis than I had been during the interviews themselves. A different interviewer, or perhaps my own later professional self, might have stayed longer with tensions around failure, power, conflict, limits or moments when outreach was not helpful. The data may therefore contain less challenge to participants' accounts than might otherwise have been present.

My own investment in outreach was also an active part of the research process. I entered the study with a strong interest in widening access and a wish to understand whether psychoanalytic work outside the clinic could be substantial and meaningful,

rather than diluted, secondary or “less than” clinic-based work. This investment supported curiosity and sensitivity to questions of access, identity, adaptation and institutional exclusion. However, it also created a risk that I would be especially receptive to accounts of creativity, warmth and therapeutic value. During the interviews, I noticed a pull to reassure participants when they appeared uncertain or self-critical, or to join them in presenting outreach positively. Alongside the effect of their seniority, my wish to show that outreach was “good enough” may have reduced my capacity to challenge or pursue difficulty.

This investment also shaped the early interpretation of the material. At points, I positioned outreach and CAMHS as opposing forms of provision, with outreach carrying flexibility, humanity and accessibility, while CAMHS carried rigidity and distance. Through repeated engagement with the transcripts and discussion in supervision, I became more aware of splitting and idealisation within this formulation. Participants also described CAMHS as providing psychiatric support, safeguarding structures, shared responsibility and the capacity to hold risk. Recognising my own pull towards a more polarised account helped me understand outreach and CAMHS as potentially interdependent rather than simply opposed. Reflexivity did not remove my influence from the analysis, but it made more visible how the findings were shaped through participants’ accounts, the interview relationships and my own professional and personal concerns.

6.1.4 Methodological and Theoretical Considerations

Reflexive Thematic Analysis was well suited to the study because it allowed me to explore patterns of meaning across different outreach contexts while remaining explicit about my role in the analytic process. It gave space to think about both what participants said directly and what seemed to be communicated through tone, emphasis, contradiction or emotional atmosphere. This was important for a study concerned with

psychoanalytic work, where meaning may not be held only in explicit description. RTA also allowed me to treat subjectivity as part of the analytic process rather than only as a problem to be removed.

There were also limitations to this methodological choice. Developing themes across four very different projects may have drawn attention towards commonality at the expense of the particular history and meaning of each project. A more case-based design might have allowed each outreach project to be explored in greater depth before considering patterns across them. Another approach might have focused more directly on how outreach projects develop and become sustainable over time. RTA remained appropriate because the study sought to explore patterns of meaning across the accounts, but the themes should still be read as interpretative constructions that organise these four accounts, rather than as fixed categories of outreach practice.

The psychoanalytic framework was another strength and source of limitation. It supported attention to affect, contradiction, atmosphere and processes that participants did not always name directly. Concepts such as transference, containment, splitting and idealisation helped me think about how relationships with services, settings and institutions were represented in the interviews. My emotional responses also became part of the analytic work, not as evidence in themselves, but as prompts for further thought. They helped me ask whether discomfort, admiration, sadness or identification might tell me something about the participant's account, the interaction between us, or my own position.

These interpretations remain provisional. Psychoanalytic concepts can deepen an analysis, but they also involve moving beyond participants' explicit words.

Interpretations such as institutional splitting, the internal frame or idealisation of outreach could be understood differently by another researcher. I tried to keep returning to the transcripts, to consider alternative readings and to use supervision to test whether

an interpretation remained close to the wider material. Even so, these processes could not make the analysis neutral. The study therefore offers one psychoanalytically informed reading of the accounts, rather than uncovering a single hidden meaning. Future research could bring other theoretical lenses, including systemic, community psychology, organisational or critical race perspectives, to examine what these frameworks make more or less visible.

6.1.5 Future Research

The study focused on clinicians' descriptions rather than direct observation of outreach practice. It offers insight into how participants thought about adaptation, containment and the frame, but less about what occurred within sessions or informal contacts, such as play, silence, interpretation, activity, boundaries and technique. A second interview or observation could have deepened understanding of the work in practice. Follow-up interviews might also have allowed participants to respond to emerging interpretations, expand on contradictions, or revisit areas that became more significant during analysis. This may have been especially useful given that my awareness of seniority, shared professional assumptions and my own reluctance to challenge became clearer later in the process.

Future research could therefore examine psychoanalytic outreach as it happens in practice. Observation, detailed case studies or follow-up interviews could explore how the frame is held moment by moment in community settings, and how therapists move between action, thought and words. Research that follows projects within their everyday settings could also show how the physical space, institutional culture and ordinary relationships around the work shape what becomes possible. Longer-term studies could trace how trust and therapeutic understanding develop across settings such as sport, theatre, nursery, school, home, community organisations and CAMHS.

Further research is also needed into the conditions that allow outreach projects to survive. This study suggests that outreach depends on more than clinical creativity. Space, supervision, staffing, safeguarding structures, funding, community partnerships and links with wider services all shape whether the work can be sustained. A national overview of existing CAPT outreach projects would help clarify where this work is taking place, what models are being used and what makes projects vulnerable. Comparative research could also examine projects that have continued alongside those that have ended, including what may have been lost and what, if anything, remained within the host organisation or community.

Finally, research is needed into how progress in outreach can be recognised without reducing it to attendance, diagnosis or symptom change alone. The accounts suggested possible indicators such as renewed engagement after rupture, movement from acting out towards shared play or reflection, increased capacity to use relationships, parent or network involvement, and thoughtful transitions into other services. These possible indicators need to be explored from the perspectives of children, families and community partners, and considered alongside more formal outcome measures. This would help strengthen the evidence base for psychoanalytic outreach while still retaining attention to relational, emotional and contextual forms of change.

The study therefore offers an exploratory and interpretative contribution. Its value lies in making visible the clinical, emotional and institutional thinking of four experienced service leads across contrasting outreach settings. Its limitations are also part of what it shows: that this work now needs to be understood through a wider range of voices, methods and perspectives. Future research can test, complicate and extend these interpretations by examining outreach as it is experienced, practised and sustained over time.

6.2 Implications

The findings have implications for how psychoanalytic outreach is understood, taught, evaluated and supported in practice. These implications are offered cautiously, given the small sample and the fact that all four participants were service leads. They should therefore be read as possibilities arising from these accounts rather than as general recommendations for all outreach work.

For clinical practice, the study highlights the need for flexibility within a grounded frame. Therapists in community settings often have to think and act under pressure, holding the meaning of behaviour and relationship while adapting technique to circumstance. Engagement itself becomes clinical work: missed sessions, brief contacts or less conventional beginnings can be understood as communication rather than failure. Adaptation is most therapeutic when role, purpose and limit are kept in mind and named clearly. Settings, language, clothing, tone and the therapist's visibility can all carry symbolic meaning and, when thought about carefully, may lower anxiety and support trust while keeping difference in mind. Safeguarding in outreach also requires attention not only to how safety is enacted, but how it is felt.

For clinical training, the findings suggest that outreach offers an important context for learning to think psychoanalytically beyond the consulting room. Training should prepare CAPTs to hold analytic thought across a wider range of settings, including schools, nurseries, faith-linked spaces, youth projects, arts and sports-based work. Experience of community-based work, whether through placements, seminars or clinical discussions, could help trainees reflect on identity, power, first contact and the emotional meaning of the setting. Teaching might emphasise using the frame flexibly, carrying it internally, articulating it clearly and negotiating it collaboratively, rather than equating it with fixed procedure. Normalising “thinking in context” and containment in

action would help future clinicians sustain analytic attention across varied activities and environments.

At a service level, the study points to the need for secure institutional holding. Outreach projects require regular supervision, dependable peer spaces, clear safeguarding structures and organisational commitment. Reflective practice is a clinical safeguard, not an optional extra. The accounts suggest that flexibility is only sustainable when therapists are held by wider systems. Privacy, continuity of space, role clarity and time for liaison are therefore symbolic as well as practical conditions. Without this infrastructure, outreach risks depending too heavily on individual goodwill, personal commitment or unpaid labour.

Policy and commissioning frameworks also play a part. Investment in early, community-based and relational provision may allow families to be met before difficulties escalate, and reframes those often described as “hard to reach” as perhaps “hardly reached.” Funding should support sustained therapeutic relationships and the wider work around them, including consultation, parent and network work, supervision, evaluation and partnership with community organisations. The ACP could also help create a national network or database of outreach projects, connecting practitioners, preserving institutional memory and making the work more visible to funders, policymakers and the profession itself.

A further implication concerns how psychoanalytic outreach becomes visible within the profession. The caution around claiming success may reflect an important clinical humility, but there may also be a cost to this caution. If outreach produces forms of progress that are relational, gradual and difficult to evidence, and if clinicians are also cautious about speaking too confidently about success, good practice may have less opportunity to enter the profession’s shared knowledge. This may contribute to a cycle in which outreach has less visibility within the profession, less research attention and

less weight when arguing for investment. If investment remains limited or short term, projects may then have less capacity to evaluate, publish and develop the evidence base. The issue is not that outreach should be reduced to simple outcomes. Rather, the profession may need to develop more confidence in researching and describing this work in ways that can hold both its complexity and its value.

Outreach and CAMHS can be understood as complementary systems rather than opposing models. Outreach may offer proximity, flexibility and a route into help for children, families and communities who might not otherwise approach clinic-based services. CAMHS can offer structure, continuity, safeguarding responsibility and access to wider multidisciplinary support. Clear pathways between outreach and CAMHS reduce splitting and allow shared responsibility for risk, endings and onward care. The implication is not that outreach should replace statutory services, but that stronger links between outreach projects, CAMHS and community partners may reduce fragmentation. A wider understanding of success is also needed, so that engagement, trust, renewed contact after rupture and increased capacity to use relationships are recognised alongside more formal outcomes.

6.3 Conclusion

This study explored how Child and Adolescent Psychotherapists work psychoanalytically outside traditional clinic settings, and what helps that work to develop and be sustained. It examined outreach projects grounded in psychoanalytic psychotherapy across schools, nurseries, youth projects, sport, theatre, faith-linked and community spaces, considering how the frame is adapted, what supports engagement, and how reflective practice is maintained within community life.

The study arose from a wish to understand what happens when psychoanalytic psychotherapy moves beyond the consulting room. Some children, young people and families may find clinic-based services difficult to access, approach or identify with, often because of cultural, social, emotional or institutional barriers. However, the findings suggest that outreach is not only about access, although access remains central. It is also about how psychoanalytic ways of thinking and working are translated across different settings. The participants described work with children, young people and families who may not have approached CAMHS, who may not have felt that therapy was for them, or whose distress was expressed in ways that did not easily fit clinic-based provision.

Across the findings, outreach emerged as a practice of adaptation that remained anchored in analytic thought. Moments of depth and understanding could arise in dynamic, relationally complex spaces when clinicians held in mind the meaning of behaviour, setting and relationship. The work often drew in families, teachers, community members and wider professional networks, held within a reflective stance that sustained analytic thinking. The significance of outreach was therefore not simply that therapists were in different places, but that they had to think carefully about how

contact could be made, how trust could develop, and how psychoanalytic attention could be sustained in unfamiliar and sometimes unpredictable conditions.

What has stayed with me most is the depth of the work described. The accounts showed therapists using their clinical training in settings where psychoanalysis may not be expected or immediately recognised. They adapted their language, clothing, timing, tone, level of activity and way of entering the setting. They thought about whether to wait, respond, speak, act, join an activity, hold a boundary or take a risk. These decisions were not separate from the clinical work. They were part of it. The therapist's presence, responsiveness and capacity to think in context became central to how the therapeutic relationship was formed and held.

Working in familiar spaces helped lower the threshold to help, allowing some families and young people to approach therapy less defensively and giving therapists insight into the social and cultural contexts around the child. Yet proximity also introduced complexity. Boundaries were tested, risk could be close, and containment had to be upheld in environments not designed for therapy. Maintaining reflection amid disruption became a central part of the work rather than a compromise. Therapists had to respond practically while continuing to think psychoanalytically. This capacity to act and think at the same time felt central.

The study also suggests that the psychoanalytic frame is not only a room, time or set of procedures. These structures matter, but they matter because of the functions they support: continuity, containment, privacy, attention to unconscious communication and the possibility of thinking about emotional experience. In outreach, these functions often had to be held in different ways. The therapist sometimes had to carry more of the frame internally, while also negotiating the work with children, families, staff, organisations and wider systems. This does not make external structure less important. Rather, it shows that internal and external forms of containment are both needed.

Outreach also brought therapists closer to risk, emotional distress and the realities surrounding children and families. Participants described work shaped by violence, exclusion, trauma, bereavement, poverty, family strain, safeguarding concerns and fragmented systems. The work required therapists to respond practically while continuing to think psychoanalytically, showing that psychoanalytic work in outreach is not removed from reality, but often takes place in direct relationship with it.

Psychoanalytic outreach psychotherapy, as revealed through the data, remained psychoanalytic in its attention to transference, unconscious communication, containment and meaning, but also required sensitivity to setting, culture, identity, power and the realities surrounding children and families. This combination widens what psychoanalytic psychotherapy can be: not confined to a single room or institution, but carried through relationships where contact and understanding can take place.

The findings also raise questions for the profession. Psychoanalytic outreach can show the reach and depth of psychoanalytic thinking, but it remains vulnerable when it depends mainly on individual commitment, short-term funding or the quiet efforts of clinicians who do not always have time to write about or evaluate their work. Participants were often cautious about claiming success, and this caution seemed clinically meaningful. At the same time, if the profession does not find ways to describe, research and value this work, some of its learning may remain hidden or be lost when projects end.

This study has shown that psychoanalytic psychotherapy can remain meaningful, and at times transformative, when practised in outreach settings. What sustains it is not the building alone, but the relationship and the therapist's capacity to think about emotional experience within context. Even brief moments of contact, play, conversation, return or recognition could open a path towards understanding. However, this work cannot depend only on individual commitment. It needs supervision, organisational

holding, safeguarding structures, stable partnerships and forms of evaluation that can recognise relational and gradual change.

Overall, I have come to understand psychoanalytic outreach as less a separate method than a way of holding psychoanalytic thinking in direct relationship with context. It asks what the child or family may need in order for help to become possible, and what the therapist, service and wider system need in order to respond safely and thoughtfully. The challenge for the profession is to recognise this work more fully: to support it, research it, speak about it with confidence, and continue developing forms of psychoanalytic practice that can meet children and families in the settings where contact and understanding can begin.

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Appendices

Appendix A: Literature Search Strategy and PRISMA Flow Diagram

This appendix provides additional detail on the literature search and screening process described in Chapter 2 (Literature Review). Figure A1 shows the PRISMA 2020 flow diagram summarising the identification, screening, and inclusion stages.

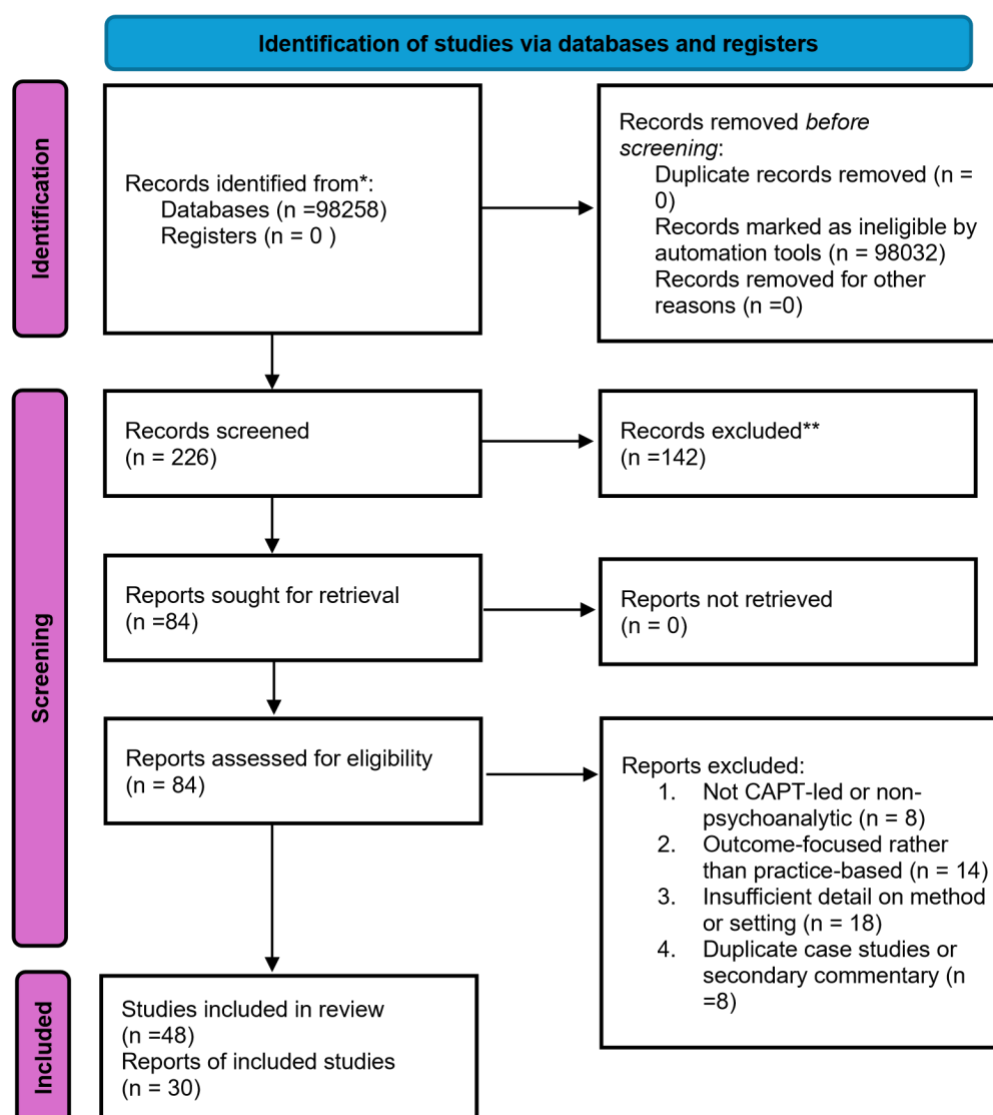


Figure A1. PRISMA 2020 flow diagram illustrating the identification, screening, and inclusion process for the literature review. Numbers reflect combined database and manual searches (April–August 2024).

Appendix B: Literature search strategy

B1. Databases and platforms

Database searches were carried out in April and August 2024 across PsycInfo, PsycArticles, PsycBooks, PsycExtra, the Psychology and Behavioural Sciences Collection, PEP Archive, MEDLINE, CINAHL, SocINDEX, Education Source, ERIC, the Tavistock & Portman Library catalogue and the Cochrane Library. Additional papers were located via Google Scholar and ResearchGate, and by following references from key texts using the snowball method.

B2. Search dates

Initial search: April 2024. Update: August 2024

B3. Boolean search structure

Table 1

Search Focus	Example terms used
Clinical modalities (S169)	(psychoanalytic psychotherapy or psychodynamic psychotherapy) OR community-based psychotherapy NOT (psychiatry or psychiatric) NOT family therapy NOT (CBT or cognitive behaviour* therapy or cognitive behavio* therapy) NOT (art therapy or art psychotherapy or creative arts therapies or expressive arts therapy)

Outreach settings (S167)	psychoanalytic project OR (community based or community-based or community program or community orientated or community focussed, or community engaged) OR community mental health OR (community setting or community-based intervention or community project) OR (third sector or nonprofit or charity) OR (outreach programs or outreach services or community outreach or outreach project)
Population (S168)	(children or kids or child) OR (young people or youth or adolescents or young adults or teenagers)
Combined search	S167 + S168 +S169

B4. Limits and filters

English language, full text; children and young people up to 25 years; psychoanalytic or psychodynamic focus; peer-reviewed at final stage.

B5. Inclusion and exclusion criteria

Include: UK-based services; projects led by qualified ACP or BAPC psychotherapists; brief, long-term or drop-in psychotherapeutic work; CAMHS-linked commissioning allowed; consultation/work discussion not automatically excluded.

Exclude: services not psychoanalytically or psychodynamically informed.

Appendix C : TREC Approval

The Tavistock and Portman 

NHS Foundation Trust

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

Tel: 020 8938 2699

<https://tavistockandportman.nhs.uk/>

Batseba Asefaw

By Email

25 January 2024

Dear Batseba,

Re: Trust Research Ethics Application

Title: *'Out of reach' to outreach: An exploration of the services and interventions that child and adolescent psychotherapists offer in an outreach setting.'*

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

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

I am copying this communication to your supervisor.

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

Yours sincerely,

Michael Franklyn



Academic Governance and Quality Officer

T: 020 938 2699

E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor, Research Lead

Appendix D: Participant Information Sheet

Participant Information Sheet

Study: 'Out of Reach' to Outreach: an exploration of the range of services that Child and Adolescent Psychotherapists offer in an outreach setting.

Study investigator: Batseba Asefaw, Child and Adolescent Psychotherapist in Doctoral Training

Thank you for your interest in participating in my professional doctorate research project. You have been provided with this information sheet to help you make an informed decision about whether you will participate in this qualitative study.

Who am I?

My name is Batseba Asefaw, and I am a Child and Adolescent Psychotherapist in Doctoral Training at the Tavistock and Portman NHS Trust. I am completing this project as an integrated part of the doctorate. I am the lead investigator for the study and will be taking responsibility for conducting your interview and data analysis. This project is sponsored and supported by The Tavistock and Portman NHS Trust and has received all relevant ethics approval (TREC). The University of Essex oversees and certifies this course as a completed part of the university programme of study.

What is the purpose of this study?

The study seeks to understand what happens to the psychoanalytic frame when applied outside clinical settings and to learn how different interventions can help address the barriers to accessing traditional Child and Adolescent psychotherapy models. This study aims to explore various outreach projects and interventions facilitated by Child Psychotherapists. The study will evaluate four to six therapeutic outreach projects that work with children and young people aged 3-25, using psychodynamic or psychoanalytic approaches.

What will participating in this study involve?

You will be invited to participate in a one-hour interview that will be conducted within the next few weeks. If you agree to participate, I will arrange a suitable time to conduct the interview with you. The interview will focus on your experience of using psychodynamic or psychoanalytic approaches to work therapeutically with children and young people in an outreach setting. During the interview, you will be asked to speak openly on the topic, with occasional prompts from me.

The interview will be conducted face-to-face at your workplace or at a mutually agreed location. However, if this is not possible, the interview will be conducted via video link. You will not be required to work beyond your usual working hours. Following the interview process, I will provide you with a Debrief Letter.

What will happen to what I say in the interview?

The interviews will be audio-recorded using a voice recorder, which I will use to playback and transcribe in full. This becomes the data set for a qualitative analysis; short excerpts may be included in the planned dissertation. At this point, the recording will be deleted securely. I will anonymise

Appendix E: Consent Form

Consent Form

Study: 'Out of Reach' to Outreach: an exploration of the range of services that Child and Adolescent Psychotherapists offer in an outreach setting.

Study investigator: Batseba Asefaw, Child and Adolescent Psychotherapist in Doctoral Training

		Please initial
1.	I voluntarily agree to participate in this research project.	
2.	I have read and understood the Participant Information Sheet for the above study. I have had the opportunity to carefully review the information and ask questions.	
3.	I understand that my participation in this study is voluntary and that I can withdraw excerpts without giving a reason at any time up to 3 weeks after the completion of the interview. I have been informed how I can withdraw excerpts of my interview data.	
4.	I understand the interview will be digitally recorded and transcribed as described in the participant information sheet.	
5.	Participants' confidentiality will be maintained unless a disclosure is made that indicates a risk of significant harm to the participants or someone else. Such disclosures or concerns would need to be shared with the relevant authority.	
6.	I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher.	
7.	I will take the best responsibility to anonymise any examples referring to cases I chose to discuss during the interview. I understand the researcher will also ensure no identifiable details make it to the final report.	
8.	I understand that the results of this research will be published in the form of a Doctoral research thesis and may also be used in future academic presentations and publications.	

If you require further discussion or have any questions, concerns, or clarification on any of the above, please feel free to leave a note here or email basefaw@tavi-port.ac.uk. I will be happy to arrange a meeting with you.

Participant's Name

Participant's Signature Date

Appendix F: Interview schedule

Interview schedule

Study: 'Out of Reach' to Outreach: an exploration of the range of services that Child and Adolescent Psychotherapists offer in an outreach setting.

This study aims to explore various outreach projects and interventions facilitated by Child Psychotherapists. The study seeks to understand what happens to the psychoanalytic frame when applied outside clinical settings and to learn how different interventions can help address the barriers to accessing traditional Child and Adolescent psychotherapy models.

Background of project:

1. Can you tell me about the service and its psychotherapeutic offer?
2. What were the motivations behind setting up this service, and what were you hoping to achieve
3. How has psychoanalysis shaped the project or been incorporated into your approach?
b. and in what ways does your approach affect the psychoanalytic frame?

Adaption in way of working and comparison traditional vs outreach:

4. How does delivering therapeutic interventions within outreach settings differ from traditional CAMHS, and what have you learned from this experience?
5. What support framework do you work within, and when the scope of support goes beyond therapeutic intervention, how does this impact therapy and how is it managed?
6. Describe the approach(es) taken to conduct assessments within the outreach setting
7. How is the service adapted to manage risk?
8. What role do communities organisations and groups play in the delivery of your work?

Accessible to therapeutic support / therapy

9. Who does your project attract that would typically not access CAMHS?
10. What have you learned about the reasons why people access this service, and how does your work contribute toward making therapy more accessible?

Evaluation of project

11. Describe how success is measured?

Appendix G : Debrief Form

Post-study information

Study: 'Out of Reach' to Outreach: an exploration of the range of services that Child and Adolescent Psychotherapists offer in an outreach setting.

Study investigator: Batseba Asefaw, Child and Adolescent Psychotherapist in Doctoral Training

Thank you very much for taking part as an interview participant. I hope you found our conversation interesting, and I look forward to developing my understanding of the complex matters we discussed later in my project. I hope to use the insights gained from our discussion to enhance our understanding of how child psychotherapists work across a diverse range of settings, using various forms of therapeutic interventions.

If you are experiencing any concerns after participating in the research project, I hope that you can access the support network around you (colleagues, supervisors, and managers). If you are not comfortable with this option, there is a confidential NHS Counselling service that you can use. You can refer yourself directly to a talking therapies service through the NHS website [Counselling - NHS \(www.nhs.uk\)](https://www.nhs.uk). The service does not require a referral from a GP. You may be offered a single session of counselling, a short course of sessions over a few weeks or months, or a longer course that lasts several months.

If you have any concerns about my conduct over the course of this interview or any other aspect of this research study, please feel free to discuss them with me (BAsefaw@tavi-port.nhs.uk) or my supervisor, Dr. Brinley Yare (BYare@tavi-port.ac.uk). You can also contact Head of Academic Governance and Quality Assurance at Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

Kind Regards,

Batseba Asefaw, Child and Adolescent Psychotherapist in Doctoral Training,
Tavistock and Portman NHS Foundation Trust, 120 Belsize Ln, London NW3 5BA