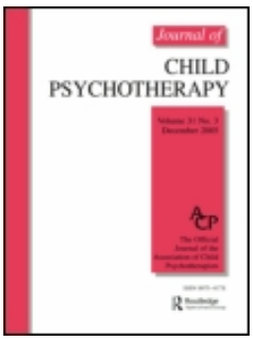

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Concentric circles of containment: a psychodynamic contribution to working in pupil referral units[1]

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This article aims to reflect on the lessons learnt from using a psychodynamic approach to offering onsite therapeutic child and adolescent mental health services (CAMHS) in four pupil referral units (henceforth referred to as PRUs). The PRUs cater for six- to 16-year-old children and adolescents permanently excluded from mainstream schools. The work takes place in an inner London borough. The approach described evolved over five years through practice-based evidence of what worked well in each particular setting. This was viewed both in terms of sustaining families' engagement in the therapeutic process, and also effectively supporting child and adolescent mental health services and education staff in their respective tasks. The model which gradually evolved owes much to Bion's concept of containment as the necessary foundation for emotional growth and genuine learning. It also draws on ideas from psychoanalytic consultation and open systems theory. The importance of work discussion groups in this setting will also be evident. Some links are made to relevant Buddhist concepts and metaphors.

Keywords: PRU; exclusion; work discussion groups; complex and unstable networks; aggressive pupils; staff support; educational settings; mindfulness

Introduction

Context

The pupil referral units (PRU)-based child and adolescent mental health services (CAMHS) described in this article forms part of a larger CAMHS in education service, which offers one day per week clinical time onsite in each of the borough's secondary schools. The primary task of our work in the PRUs as agreed by CAMHS and the local education service is to reach out to an often disaffected and socially excluded population. The aim is to attempt to address their emotional and mental health needs, which in turn is hoped to help improve their overall quality of life and future prognosis in terms of mental illness, social deprivation and delinquency. Exclusion from mainstream education has been found in many studies to be a significant contributing factor to wider social exclusion from mainstream society as an adult (e.g. Baruch, 2001). Therefore, we also contribute to planning and joint thinking with each PRU's education staff about how to best meet their particular

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population's emotional needs in the context of the classroom and playground. The aim is to help pupils towards reintegration into mainstream education where viable.

Clinicians work in multidisciplinary pairs in each of the four PRUs for an average of three days per week, overlapping for at least half a day onsite in order to facilitate team building and joint working. The child psychotherapists in the service undertake a range of clinical work spanning assessments, brief interventions and individual supportive psychotherapy (Kernberg, 1999). We have found that substantial technical adaptations are often necessary in order to engage this population, and to effectively work with them in the singularly uncontained PRU setting. This is a subject that I will return to in the main body of this article.

The service's main constraint apart from funding is our place as a commissioned service at the edge of our host institutions. We are without any managerial or decision-making power within the PRUs or within local education decision making in general. This can be extremely frustrating and at times it actively obstructs our therapeutic efforts, for example, when a child we are working with is suddenly moved to a new school without warning. On a bigger organisational scale, decisions can be made to close, amalgamate or change the remit or leadership of the PRUs, often at short notice. Managing the boundary of the system we are operating within is thus complicated by finding ourselves with a lot of influence but no executive authority. Our service has been greatly helped in navigating our way through the troubled waters of the PRU as a clinical setting by Zagier-Roberts' (1994) conceptualisation of organisations as open systems with a permeable boundary, where outreach professionals are located. This provided us with a map and coordinates for defining both our place in the PRUs, and our primary task.

As coordinator of provision into the PRUs over five years, I was part of several management meetings as the CAMHS representative. In addition, I regularly liaised with the educational director of the PRUs and the head of each PRU, in a kind of troubleshooting capacity. One way of conceptualising this situation is that multiple and overlapping concentric rings of emotional containment needed to be put in place by managers and supervisors in the Service. This then made it possible for the PRU psychotherapists to keep steady in carrying out their primary clinical task in this chronically unstable setting.

Aims of this article

I would like to demonstrate the centrality of Bion's concept of containment to the success of our service's current way of working in PRUs. This will be explored with reference to a clinical example. This way of working evolved by trial and error over a period of five years. Containment is offered in concentric circles around the children, their families, the PRU and its staff group and the service as a whole in its multi-agency context. I hope to demonstrate that in this way, meaningful and transformative therapeutic work can become possible in the characteristically unstable and unpredictable setting of a PRU. It is hoped that the model described might yield ideas applicable to working effectively in other unstable organisations whose brief is never clear and ever-changing.

Finally, with the help of further case vignettes I am also aiming to show how working in challenging settings like PRUs with dysfunctional and fragmented families might serve us as 'helping professionals'. I want to raise questions about developing a gradual understanding of how to contain our own and each others'

primitive survival fears in an ecologically and politically increasingly unstable world. In this context, I would like to explore Cooper's and Dartington's (2004) theoretical ideas about expanding Bion's concept of containment to make sense of organisational life. They discuss our contemporary experience of a world where all the old familiar containing institutions appear to be fragmenting at an alarming rate and are then recombining in rapidly shifting and changing constellations. This can be experienced as terrifying in a persecuted state of mind or full of creative potential when we are feeling internally secure and positive. Cooper and Dartington's suggestion is that we urgently need to think about how to retain our sanity within this new, shape-shifting container of a complex, non-linear, ever-changing network of interweaving connections. They suggest the world-wide web as a prototype. Alternatively, one classic Buddhist image for our complex, interconnected world is a moving and swaying net of jewels caught at different angles by the light of the sun and the moon.

Concentric circles of containment

Here is an everyday image of interconnectedness: concentric rings formed by rain falling on water, which will in turn affect the movements of the little paper boat (Figure 1). It is an image evocative of the overlapping concentric rings of containment that we sought to achieve for children attending PRUs, their families and networks and the staff teams working in PRUs.

I now want to describe a piece of long-term parallel psychodynamic work with a parent and young person which had a positive clinical outcome. This family proved unexpectedly responsive to this kind of in depth intervention, despite a previous history of dropping out of clinic-based interventions. It seemed particularly important that the re-negotiation of therapeutic work with this family was gradual and flexible. I have disguised any identifying features for reasons of confidentiality.

Tyrone was referred to our service at age 13, when his infrequent but extremely violent outbursts were thought to present 'a health and safety risk' to pupils and staff. He was facing exclusion for that reason. Tyrone had been at the PRU for

Figure 1. Concentric circles.

almost two years, having transferred from the primary PRU at secondary transfer. The Head of the PRU was aware that Tyrone was a child with emotional, behavioural and specific learning difficulties in literacy who had never managed mainstream education in his entire school career. It was accepted that Tyrone required a place in a special school for children and adolescents with emotional and behavioural difficulties where his complex needs could be met. However, as there was no such provision in the locality, Tyrone had ended up staying in the PRU on a long-term basis by default. This unsatisfactory arrangement was a main source of frustration for Tyrone and his mother. Tyrone's mother regularly raged at teaching staff when she was contacted about yet another behaviour incident involving Tyrone. She blamed the staff for not being able to manage her son and for not finding him a suitable school. She often accused staff of racism towards her son and herself. The referral to us was thus a somewhat desperate last ditch attempt 'not to have to exclude Tyrone into nowhere'. Nobody could make any sense of Tyrone's sudden 'attacks' as he himself called them, when most of the time he was a gentle and cooperative boy, motivated to learn, albeit somewhat on his own terms.

Reading Tyrone's files did not give us much hope of being able to help in this situation. There had been numerous CAMHS referrals over the years, all of which were either not attended at all or ended up with the family prematurely ending treatment. In other words, no suitable container had so far been found for either Tyrone or his family – they kept on 'spilling out'. Because of the urgency of Tyrone's situation and the need to firmly engage his mother from the outset if we were going to have any chance of intervening successfully, two clinicians assessed the family. This gave scope for a number of separate, parallel sessions for Tyrone and his mother, following a joint introductory meeting.

In our first meeting we listened to a formidable outpouring of grievances against the education and health systems from both mother and son. However, we also heard the extraordinary story of a family car accident when Tyrone was a year old. He had suffered severe facial injuries, temporarily losing his speech, ability to eat and the sight of one eye. Significantly, his two-year-old brother and mother's unborn baby escaped without injury. Although we had read about this event on file, it was still profoundly shocking to hear at first hand. I now think that post traumatic stress arising from the accident accounted for some of Tyrone' subsequent severe behavioural difficulties. Moreover, the accident also became an unconscious metaphor for what must have felt like a catastrophic family breakdown at the time, as the accident coincided with the parents' separation. The repeated, detailed account of the accident evoked the sense of a recurring nightmare depicting utter ruin. This was the case for the internal worlds of both Tyrone and his mother – the secure container of their family had been attacked and broken, threatening survival.

Mother and son agreed to the offer of once weekly psychotherapy, with parallel once monthly parent work sessions for mother. Both Tyrone and his mother preferred the therapeutic work to be based at the CAMHS clinic, separate from the PRU which neither of them experienced as a good or safe place at the time. It was interesting that what Tyrone's mother had reacted against in previous CAMHS interventions was that they were too rigid. She criticised the former professional's fixed views about the likely nature and causes of her difficulties with her son. Once Tyrone and his mother perceived us as receptive and flexible in this

regard, their previous difficulties in sustaining engagement did not recur. This case illustrated what we found with many other PRU families: that parents had not felt able to engage with clinic-based CAMHS proposing to offer a well-recognised treatment package, because it made them feel they had no voice in the decision making about what would be helpful to them, and because they had felt implicitly judged and blamed for their child's difficulties. We also found that many traumatised and emotionally deprived families had experienced a clinic-based CAMHS setting as intimidating and institutionalised, while they were more able to respond positively to the more informal outreach setting. Tyrone's mother remarked that this time she did not feel patronised and blamed for her son's difficulties, because we had listened and responded to her point of view. She felt relieved that we had not insisted on her entire family being included in the therapeutic work. Mother explained later in our work together that she felt very sensitive to not being understood or taken seriously, due to her own history of displacement from her country of origin and subsequent frequent experiences of racism in this country.

The first circle of containment: individual psychotherapy

Tyrone's subsequent individual assessment sessions with my colleague, and much of his subsequent year-long once-a-week psychotherapy were dominated by material related to the accident, which Tyrone did not consciously remember. He had always felt he had been singled out in his family to bear the brunt of things, and that neither of his parents cared whether he lived or died. He was able to modify this view over time and his relationship with both parents gradually improved significantly. He was also able to curb his extreme risk-taking behaviours in the community (e.g. dangerous climbing, jumping and 'free running' stunts) once he felt more confident that he was cared about.

Tyrone's attitude to his therapy was fairly uncomplicated from the start: ''It's only talking, but somehow I suppose it does help.'' He was able to bring problematic situations at home and at the PRU to his sessions to be thought about and he began to make more collaborative relationships with his parents, siblings and teachers. In addition, he became more able to identify potential triggers that were likely to get him into a rage. For instance, when people were 'in his face', he blanked out, lost control and then didn't know what he was doing any more. Making explicit the possible link with his early trauma was very helpful to him, allowing him to step back slightly at times. Tyrone's psychotherapy came to a planned, if rather sudden ending following a crisis in his attendance towards the end of the academic year. However, he was able to attend a joint review meeting with his mother, his therapist and myself to explain that he had begun to find the journey to and from the PRU 'for only 50 minutes' too hard, especially as he was being stopped and searched by the police quite a lot en route. On reflection together, we arranged for him to transfer to seeing a PRU-based clinician the following year in his new Keystage 4 PRU, and he managed to attend a number of ending sessions with his therapist on that basis. He expressed his sadness at having to say goodbye and start with a new person, but concluded that this was the best possible solution. With his new therapist, he is beginning to explore wider issues of adolescent development and what it means to him to be growing up into a young man.

The second circle of containment: parent work

In my assessment sessions with Tyrone's mother, I began by asking her what had not worked from her point of view in previous CAMHS involvement, drawing her attention to the repeated dropouts from treatment. I explained that this time we wanted to make sure we were offering something which genuinely made sense and was helpful to her and Tyrone. She remarked that ''someone actually listening to her point of view would be a first'', adding that she felt like hitting the next person who suggested to her that her difficulties were due to being a single parent of several children. She emphasised that her difficulties were with Tyrone and always had been – ever since he had 'changed personality after the accident'. He had been a placid and contented baby and toddler up to then, 'a raving lunatic' thereafter. Mother clearly partly blamed herself as the children had not been strapped into their car seats at the time of the accident; but this remained a difficult area we could only occasionally and obliquely consider.

She remained wary of the parent work component of the treatment for some time, as it was reminiscent of earlier suggestions of family work which she had always resisted. She relaxed gradually when she realised I was not out to trick her into any pre-formed view of where her parenting difficulties lay, but listened to whatever she brought and then tried to think with her about it. To begin with, our work focussed exclusively on her conflicted relationship with Tyrone, but over time as this relationship improved, she brought situations with her other children too. This case did make me question our often perhaps stubborn insistence in the clinic-based service on starting with family work before considering specialist individual therapeutic input, rather than simply starting with whatever makes sense to the family we are trying to help. The family's views might also reveal important information about their own cultural and family backgrounds, and our being open to ways of approaching difficulties different from our own western perceptions could in my view potentially greatly enrich the quality of our work. It is pertinent to reflect that with this attitude of a more flexible container in mind, Tyrone and his mother may have been able to receive specialist help much earlier in his life.

The third circle of containment: holding the network

At various points, network meetings became necessary whenever the situation around Tyrone's long-term education plans reached boiling point. Giving Tyrone's mother the opportunity to express her views freely in this forum meant she felt listened to and taken seriously. She gradually realised that the head and teaching staff of the PRU were doing their best for Tyrone in the circumstances. She began to accept that they were not to blame for the lack of special school places in the locality and could not do very much about this unfortunate situation. This enabled mother to cooperatively work with staff, rather than against them which in turn had a positive effect on Tyrone' attitude to being in the PRU. Teaching staff then were more willing to make an effort to meet Tyrone's particular needs as he was more responsive and his mother openly appreciated their efforts. Quite soon, Tyrone was no longer regarded as a health and safety risk and he began to progress in his learning beyond all expectations, reaching age appropriate national curriculum levels in maths and science at the end of Keystage 3.

The fourth circle of containment: staff work discussion group

The final circle of containment in this rewarding case was the staff work discussion group we offered on a fortnightly basis in the PRU that Tyrone attended. Work discussion is a method for reflecting on the work setting and its emotional impact which was first developed as part of the child psychotherapy training at the Tavistock Centre in the 1960s. It has since then been adapted for use in many professional settings by psychotherapists working with staff groups (Rustin and Bradley, 2008). In the PRUs, fortnightly one-hour meetings were co-facilitated by two child psychotherapists. I will describe a work discussion session focussing on Tyrone in some detail here. This illustrates the potentially powerful effect of this intervention on staff attitudes towards particular young people, through enhanced understanding which is achieved collaboratively. I felt encouraged to pilot work discussion groups in the PRUs after reading Jackson's (2005, 2008) papers on his application of this method to secondary school staff teams. I was particularly interested in his unexpected finding when evaluating this intervention, namely its positive effect on staff retention and sickness leave absences. Both of these factors often reach problematic levels in the PRUs.

The session described took place quite soon after Tyrone's referral, when we had just heard the story of the accident in his infancy and had begun to put together the pieces of the puzzle of his 'attacks' of rage. It also demonstrates how our thoughts about Tyrone and his mother were taken seriously by staff because we were known to be directly working with them. We have repeatedly found that carrying out direct therapeutic work with the pupils and their families *and* offering a work discussion group to staff is a powerful combination. It undermines any sense of hierarchy and illustrates the fact that we are all working with and trying to help and understand these young people as best we can in our different roles. We explain to PRU staff that the content of therapeutic sessions is strictly confidential, as might be the details of their family situations. However, many young people and their families actively welcome our sharing of relevant factors in their backgrounds with PRU staff, so that they can gain a greater understanding of their emotional and behavioural difficulties. When there is recognition of the links between the young people's home backgrounds and their reactive behaviours at the PRU, staff often begin to feel more empathetic and creative in their responses to the troubled young people in their charge.

Furthermore, staff members themselves have sometimes chosen to work in a PRU because of their own problematic life experiences which make them identify with the role of outsiders, excluded from mainstream society. They can also at times project their own unconscious delinquent aspects into their students, vicariously living out these tendencies. This can lead to unhelpfully collusive relationships between staff and students. Bringing the complex dynamics between staff and children into consciousness in an empathetic way makes staff work discussion groups a powerful intervention, alongside direct clinical work with the children and families.

The work discussion group concerning Tyrone was one of our early meetings, when the staff group was still getting used to this new forum. We were therefore surprised to find staff assembled in the right place almost on time. Tim, one of the teaching assistants, announced nervously that he thought he might as well bring a written incident report to get us started and he had made copies for everyone. It was quite a brief, barren and factual report, but we were impressed by the effort made by

Tim, as we had given staff the option of verbal presentations if they had no time to write anything down during the week.

The incident he described had been a sudden verbal attack by Tyrone followed by physical threats towards Tim, when he announced a change in Tyrone's timetable. This amounted to Tyrone's withdrawal from a lesson where he had lately been particularly confrontational and disruptive. Tim had felt shocked and angry at Tyrone flaring up at him, and had responded by sending him to the Head's office until he had calmed down. Tyrone had raged and sworn, threatened to hurt the Head and 'smash the place up'. He had finally been excluded and escorted from the premises by his mother, who had been equally furious with staff for not having been able to manage her son's behaviour. She had shouted and sworn at the Head in her office before storming off with her son in tow.

During that early period in our involvement with the family, this kind of situation was a fairly regular occurrence for Tyrone and his mother. Staff around the table immediately sympathised with Tim and argued for Tyrone to be permanently excluded from the PRU, as he clearly presented 'a health and safety risk'. They couldn't understand why the Head still put up with Tyrone's outrageous behaviour and they were critical of his mother's collusion with him.

The Head reminded her staff that there was nowhere else for Tyrone to go, and that they had no choice but to keep him at the PRU until a place in a special school for pupils with emotional and behavioural difficulties had been found for him. She added that she thought Tyrone's mother shared the exasperation of the staff about the situation and she got angry because she was stressed and panicked about her son's future. One of the teachers ventured that Tyrone's mother did always come back and genuinely apologise after one of her outbursts at them. Tim sarcastically countered that Tyrone also did so, but that he was no longer prepared to accept his apologies, as he always ended up doing the same thing again.

We remarked that we seemed to have entered into a very concrete debate as to whether or not Tyrone should be permanently excluded. We reminded the group that work discussion was a thinking space to help us try and understand what might be going on for a particular pupil and what he evoked for them as a staff team. The music teacher who had been silent up to this point almost exploded and declared that "it was bloody obvious that everyone here agreed that this was the wrong place for Tyrone because he was too violent and dangerous". After a brief silence, several teachers pointed out that Tyrone had not actually been violent in several weeks, although his verbal threats of violence had been intimidating and alarming. It further emerged that the verbal threats had also been relatively infrequent recently, but they continued to be very extreme in their nature when they did occur. We then suddenly heard many positive accounts of how thoughtful and engaging Tyrone could be at other times.

Tyrone's therapist remarked that he had so far encountered only the thoughtful and engaged side of Tyrone and as yet he had never felt threatened by him. He wondered if perhaps there was something in the group or classroom setting which triggered his anger? This led to a discussion indicating that nobody could pinpoint a particular trigger for Tyrone's outbursts – they seemed to occur unpredictably out of the blue – and they quickly became unmanageable for him and those around him. We made a link with the catastrophic car crash early in Tyrone's life which was known to staff, and speculated about Tyrone's rages being some kind of PTSD enactment of the shock of that road accident. Tim revealed that he had worked with traumatised children before and thought this was possible. He observed that Tyrone

often wanted to 'smash someone's face in' and flipped when closely confronted: ''Get out of my face!'' Wasn't it his face that was injured in the crash? We confirmed that this had indeed been the case.

A wider discussion followed, initiated by the music teacher, about the role of the PRU and what type of children the staff felt they could really help. There was a strong suggestion that children like Tyrone and several others currently on their roll needed a different set of skills and knowledge. It was thought that psychotherapists might be able to understand and help them, but that the teaching and support staff felt inadequate in the face of Tyrone's disturbance and did not know what to do. We challenged this with examples where we in our therapeutic work often felt defeated and inadequate and we encouraged staff to see this as a potential communication about how the children might feel themselves. This elicited a flood of examples demonstrating just how insecure, scared, confused and inadequate Tyrone often felt at the PRU. The music teacher still insisted this was because he was in the wrong place. The head agreed and stressed that she would continue to press for a special school place to be found for Tyrone as a matter of urgency. However, she added that maybe any school would say the same thing about ''someone like Tyrone who just didn't neatly fit''. ''Who does?'' someone asked, which led to a humorous conversation about the PRU as a collection of misfits; pupils and staff alike.

The atmosphere in the room and the quality of interactions shifted during this meeting. To put it in Kleinian terms, there was movement from the paranoid schizoid to the depressive position (Klein, 1932), with emerging empathy and concern for Tyrone and his mother. There was a new willingness to relinquish the earlier harsh wish expressed by the teachers to get rid of Tyrone as quickly as possible. This shift had a lasting effect. The meeting marked a turning point and the beginning of improvement in Tyrone's relationships with his teachers, a lessening of his challenging behaviour and a greater ability to focus on his learning.

Shifting paradigms: from secure containers to open networks

> It seems that where there was a border, now there is a network. In its luminous aspect, it is a symbol-generating and containing fabric that modulates, diversifies and expands. In its ominous aspect, it spells dislocation, disintegration and degradation.
>
> (Abadi 2003, quoted in Huffington et al., 2004:127)

Psychoanalytic theory has always been interested in the relationship between emotional development, thinking and learning. Waddell (1988) offers a brilliantly succinct summary of Freud's, Klein's and subsequently Bion's understanding of these matters when she considers models of learning. She concludes that an individual's ability to take things in genuinely and use them in the service of personal growth and development depends on their earliest experiences of secure emotional containment. Bion's prototype for his concept of containment was a mother calmly bearing her baby's 'nameless dread' of annihilation, transforming it through her caring and holding presence, and returning the intense emotions involved to the baby in less catastrophic and more manageable form (Bion, 1962). The hope is that this eventually helps the baby to internalise a good, caring, warm presence or object which can help him with his pain and fear.

Children referred to PRUs often come with a history of problematic discordant early relationships between mother and baby. The child is likely to resort to

mechanisms of projection or adhesive identification rather than introjection (Klein, 1932) when faced with new and challenging experiences of uncertainty and not knowing.

In the context of families of children and young people attending PRUs, attachment relationships between children and parents or carers are almost universally insecure, and often in the disorganised category. Patterns of neglect and abuse can frequently be traced back over several generations. Many children have been diagnosed with ADHD, conduct disorder and/or oppositional defiant disorder by the time we see them. Often they appear to have very little capacity to contain their own emotions. Rage, fear and distress tend to be directly and instantly acted out through the body. This takes the form of acts of self-harm or aggression towards others, running away, uncontrollable crying and verbal expressions of suicidal feelings. These behaviours are extremely upsetting and frightening to witness at times for the staff working with these children. Some children will desperately cling to particular members of staff and become extremely dependent on them. Others project their intolerable feelings into staff and quickly become seen as unmanageable and face the threat of exclusion yet again. More often than not, any one child may use a chaotic mixture of these methods at different times and in different situations. Thus, they are experienced as entirely unpredictable and wild – 'feral', as the tabloid newspapers have termed it. Here is a brief clinical illustration of how it can be at least momentarily possible to contain these children's extremely persecuted states of mind in therapy:

> *Abi, aged 14 years, came along eagerly, and explicitly sought my advice in helping her control her temper. She vividly described out of control situations in the community where she regularly put herself at risk of serious injury through her provocative behaviour with adults. She enjoyed the drama of running away and hiding afterwards. Alternatively she actually got into a physical fight. She fully assumed my weekends and evenings were spent in a similar fashion, thus revealing how there was no boundary in her mind between children and adults, or reckless versus responsible behaviour. She was astonished when I reflected this back to her, suggesting implicitly that there might be other ways of being. She gradually began to see the PRU as a safe place with the help of a number of sensitive and caring teachers to whom she cautiously attached. A breakthrough occurred when she described to me an incident where she had lost her temper in class and 'started trashing the place'. Then she suddenly thought to herself that she did not want to be excluded again, and had sat down, calmed down, and then repaired the damage she had caused and apologised to her teachers. She had been moved and grateful that as a result she had not been excluded. She kept on repeating that she had never done anything like this before – meaning stepping back to think, and being able to calm herself down. This proved to be the high point of her progress in making helpful relationships with teachers and peers at the unit, and of our work together.*

In classic psychoanalytic theory, the treatment setting is conceptualised as a closed, secure container, where the patients can gradually begin to feel safe enough to communicate the disorder of their inner worlds. This is facilitated by the unchanging external boundaries of a reliable and confidential therapeutic space, represented by the therapy room, and the therapist's undivided attention within the fixed 50-minute timeframe, which are arranged at regular intervals.

This way of working is impossible in the PRU setting – not only because the external environment is bound to be unpredictable, but also because the children's states of mind are often too disturbed to be able to tolerate such a setting. Many feel intensely claustrophobic and persecuted when faced with a one to one encounter in a closed room. It may be necessary to spend long periods of time beginning to engage a

young person in a meaningful conversation, however short, and wherever on the premises. The containing frame in PRU work could be described as the therapist's full, empathetic attention at every moment of encounter with these children, however fragmented and brief. In Buddhist terms, the basic attitudes to aim for at each moment and in every situation are mindfulness and compassion. This conveys an emotionally containing state of mind which can be trusted to exert at least a measure of a beneficial effect on the most chaotic of settings and situations. It is in accordance with Music and Hall's (2008) view too about delivering therapeutic work in schools. The containing framework in such settings only reveals itself in the therapist's clear, calm and receptive attitude, rather than a reliance on a stable and consistent external setting. What supports the therapeutic work is the positive working relationship between therapists and educational staff. Young people are much more likely to sustain engagement in therapy if this is actively and consistently supported by their teachers. The therapeutic work is also endorsed if the young person can witness their teachers and therapists thinking and working creatively together on their behalf during crisis periods.

The other difference between classic psychotherapy and PRU work is that most of the time, the therapist herself would actively and directly establish links with the parents, PRU staff and other members of the professional network. This is in contrast to the parent work and network liaison being done separately by a colleague. The reason for this is that if a level of trust can be established between child, therapist and the child's parents or carers, we have found that often parents of children in PRUs are willing to meet with and speak to the person who is directly trying to help their child, while many are not able or willing to engage with a separate clinician. They are also then more likely to accept even challenging advice and communication with social workers and teachers by the person they feel 'knows their child'. The therapist working with their child, they feel, understands the particular difficulties that they are struggling with in their parental relationship with their child. Thus, at times the whole professional network can gradually become a good enough container for the whole family, if coordinated sensitively by the professionals involved. However, getting the combination and timing of complex interventions right when families are in severe crisis can be extremely difficult:

> *When the social worker made another request for parent work with a mother who had not managed to sustain engagement in this kind of work ever before, I suggested we carry out a brief, joint parent work assessment together. This was in order to ascertain mother's capacity to engage in this kind of work, and thus to change her parenting style. The social worker reluctantly agreed that if mother failed to engage this time, he would need to consider alternative care for her son Ibrahim, aged 15 years, an option he had hitherto resisted. I structured the parent work assessment like a psychotherapy assessment. I offered three parent work sessions to mother, sandwiched by a joint introductory and a review and planning meeting with mother and Ibrahim's social worker. This proved to be a powerful tool, finally leading to a significant shift in a network which had got stuck around a social worker's private passion to keep this particular family together, at any cost. Briefly, mother managed to attend two out of three offered sessions and she directly asked me to help her communicate to Ibrahim's social worker the severity of her parenting difficulties in relation to her eldest son.*
>
> *A moderate degree of learning difficulties in mother in combination with extreme emotional deprivation in her own childhood came to light, which made it impossible for her to meet her eldest son's considerable emotional needs. She acknowledged that she switched erratically between a harsh, punitive approach and a collusive/indulgent attitude towards him. She admitted that she did not know how to be both firm and understanding towards*

him at the same time. It made sense to her when I reflected back to her the difficulty of a single parent who had to simultaneously be mother and father to her children. She felt more able to manage with her younger children who had a different father, but it was difficult for her with Ibrahim. This was due to the particularly violent and traumatic quality of the relationship between his mother and father around the time of Ibrahim's conception and birth. Mother admitted that when Ibrahim had set a fire in the home the previous week, she had reached the end of her tether with Ibrahim. She now feared for his, her own and her younger children's safety if he remained in her care.

Tragically, Ibrahim physically assaulted his mother the night before our planned network review meeting. He was arrested and the next day placed into emergency foster care. I could not help wondering whether this sad outcome could have been prevented if I had earlier suggested a formal parent work assessment. I also wondered if following her disclosures to me which had also clarified the situation in her own mind, Ibrahim's mother had unconsciously provoked his attack on her, in order to force care proceedings? The alternative from mother's point of view would have been a far slower process. Given her learning difficulties, was she unable to tolerate waiting any longer, after having expressed to me her greatest fears about her own sanity, and her younger children's lives?

Perhaps the clinical task in a case like the one described is to look with a psychodynamic lens at the family's current situation within their community and professional network. Then a decision is necessary about the nature and timing of the intervention in order to constructively shift their situation. I have been looking at this in terms of Bion's idea of allowing the selected fact to emerge from a clinical encounter; to find the central knot, the heart of the matter, whatever we want to call it (Bion, 1962). Then there can be an intervention at that nodal point, to enable a stuck situation to gradually disentangle itself, or even to unravel, as was unfortunately necessary in the case described above. Perhaps the container in PRU work is attending to the intricate web of complex and open-ended interconnections between a child's internal emotional difficulties, their disturbed relationships with family members, peers and teachers and the quality of the family's relationships with the professional network trying to help them with these difficulties. The PRU clinician may choose to intervene by working with the child directly, with the parent or carer, the family, with the professional network or with a flexible combination of these possibilities. The optimal situation is when various interventions shift and change according to clinical need.

The uncertain role of PRUs in terms of their primary task, and the resulting constant flow of sudden changes in policy are another layer of complexity for the clinician to contend with. High staff turnover presents an additional challenge. Good supervision and peer support are crucial to help clinicians gain and retain perspective in this ever-shifting and changing clinical situation. In the case quoted above, Ibrahim had been able to make creative and constructive use of once-a-week art therapy sessions prior to the family crisis. He had expressed his desperate efforts to retain control over his aggression in meticulous paintings reminiscent of Mondrian's abstract phase. However, as Ibrahim's emotional state deteriorated, he was unable to maintain this level of self-control and his art therapy had to be stopped when he started breaking into cupboards and stealing expensive equipment. It appeared that he was acting out his extreme emotional deprivation and as he had become more aware of it, uncontrollable rage and envy was evoked in him.

It was this particularly problematic but also potentially highly creative 'shape-shifting' characteristic of the PRU work that I was reminded of when reading Cooper and Dartington's (2004) idea of the 'vanishing organization'. They describe

the recent profound change in organisations in general as a result of the internet revolution, which lead to much more fluid and less rigidly boundaried ways of operating. As the quote from Adadi at the beginning of this section expresses, this new paradigm of an open network rather than a closed border has creative as well as destructive potential for human endeavours and relationships. Cooper and Dartington (2004) use the classic psychoanalytic image of a baby securely held by its mother, both supported by the father, as the image to illustrate the well-functioning traditional, hierarchical organisation. This implies a structure boundaried by the roles, task and levels of authority each person holds within it. In contrast, the new, open and interlinking networks no longer function like a bigger version of a nuclear family, as they are outward-looking and non-hierarchical. Thus, leadership functions are particularly difficult to carry out. Cooper and Dartington give a vivid example of a public sector manager almost driven mad by confusion and uncertainty amid the constant shifts and changes in her role and level of authority in relation to each particular task she carries out during her day.

In both my coordinating and clinical roles within the child and adolescent services based at PRUs I have recognised the unsettling and anxiety-provoking feelings that are evoked. I became more mindful of a preoccupation with survival issues in working within this stressful, 'unparented' situation. Routine questions for us all were to do with how to get through the day – or indeed through a session with a child or family; how to maintain our status and funding; we were constantly thinking about the potential risks involved in a particular course of action. There was often despair about the apparent futility of what we were trying to achieve: to help families and children who often proved beyond our capacity to intervene successfully. We often used the image of 'living on a tectonic plate' or at the edge of a volcanic crater, never any safe or solid ground under our feet.

On the other hand there were moments of joy and excitement when we were able to make meaningful emotional contact with a child or family, or after an insightful work discussion group which had helped to shift a stuck dynamic. Perhaps one of the most important lessons I took away from my work in this particular service was not to count on an overall positive outcome of a particular clinical intervention. This was often unrealistic in the circumstances. Instead, it was important to value each constructive and meaningful clinical encounter as important in its own right. A moment of emotionally containing contact with the child or family or indeed with the staff group was noteworthy, however fleeting. Such moments could be remembered as something positive that was possible between people. They ran counter to mutual attack or cutting off from painful experiences. In our clinic-based service I worked with a parent of a child attending a PRU for four years who was able to reliably bring her son for regular once-a-week psychotherapy sessions with my colleague throughout that time. This was because she remembered, even in her most despairing moments, a few therapeutic sessions her own mother had managed to bring her to as a child, and how it had helped her to sit and draw while someone was genuinely interested in how she was feeling and accepting of her even when she was unable to communicate. Another extremely deprived mother I work with keeps returning, albeit irregularly, because my letters during her absences make her feel kept in mind and cared about. Both these parents appear to have valued an experience of emotional containment, however brief or distant.

Concluding thoughts

From a psychoanalytic perspective, in a problematic situation what is first and foremost of importance is a secure and containing forum where people can come together, listen to each other and take the necessary time and space to think together. When there are efforts to make sense of whatever is happening, then it becomes more possible to find a constructive, creative rather than reactive way forward together. The model which evolved in the CAMHS outreach service described in this article was to apply this simple yet profound principle of containment to multiple levels. We worked to form concentric circles of containment: around each child and family and around the PRU staff group as well as around each clinician and pair of clinicians on each site (through supervision), the PRU clinician team as a whole (through regular case discussion meetings); and the multi-agency professional network. At least some of the young people, their parents and the PRU teaching staff seemed to recognise the containing thinking space thus created as valuable in itself, perhaps regardless of the specific outcome of a particular situation or intervention.

I would hope that there is scope for adapting and developing this method of working in other community-based settings. As stated above, the general principle of overlapping sets of concentric rings of containment might lend itself particularly well to working in many contemporary settings. This is especially so where there is no longer a stable, firmly boundaried institution to work within, but instead an open and ever-changing network of complex organisational relationships to be negotiated.

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Note

1. Margaret Rustin first coined the phrase 'concentric circles of containment' at the International therapeutic work in educational settings conference in Naples in November 2007.

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